

Infant wellbeing and monitoring: **An observation of the Road to Health Booklet** **in Masiphumelele**

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This paper is submitted in partial fulfilment of the requirements for the award of a degree of Master of Social Science, specialising in Anthropology.

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Pink for girls



Green for boys

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To my family and friends, thank you for the support you have given me

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ABBREVIATIONS AND ACRONYMS

DoH - Department of Health

RtHC - Road to Health Card

RtHB - Road to Health Booklet

UNICEF - United Nations Children's Fund

WHO - World Health Organisation

PHC - Primary Health Care

HIV - Human Immunodeficiency Virus

Aids - Acquired Immunodeficiency Syndrome

MDGs - Millennium Development Goals

SDGs - Sustainable Development Goals

IRR - Institute of Race Relations

UNDP - United Nations Development Programme

PMTCT - Prevention of Mother to Child Transmission

MUAC - Mid-Upper Arm Circumference

UNICEF - United Nations International Children's Emergency Fund

ARVs - Antiretroviral Drugs

TB – Tuberculosis

ECD – Early Childhood Development

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Infant wellbeing and monitoring: **An observation of the Road to Health Booklet** **in Masiphumelele**

Abstract

The South African government monitors and tracks the health of new-borns and the growth of children. The Department of Health (DoH) does this monitoring using the Road to Health Booklet (RtHB). In this dissertation I analyse the use of the booklet in the township of Masiphumelele in Cape Town. The state produced booklet is intended for the child and mother as a patient-held medical health record. Liaw (1993) defines a patient-held record as notes or space provided on a document for the recording of follow up appointments for further investigation by medical doctors. The RtHB is used to record the child's development, immunisations and HIV related information from birth to the age of twelve years. The dissertation results from ethnographic research with eight black Xhosa¹ mothers and caregivers with children under the age of five years old. Mosley, and Chen, (1984), argue that in developing countries where standard child healthcare has been made available, children should survive the first five years of life. In my research, during the period of six weeks between July, August and September 2017, I followed the booklet in to Masiphumelele. From my observation and semi-structured interviews, looking at the state's role of 'pastoral' care, child wellbeing and living in a township, and recording, under the theme of child wellbeing, certain concepts emerged. These concepts were state power, mothering, caring for children, responsabilisation, gender, kinship, fatherhood, child wellbeing knowledge production, social networking. In this dissertation I use ethnographic findings, accompanied by my own personal narratives. I argue that tracking child wellbeing through this booklet, the state exercises what Foucault (1982) referred to as 'pastoral power' in ensuring the wellbeing of the populations.

Key words: road to health booklet; state; pastoral power; governmentality; wellbeing;

¹ Black is a socially constructed term to refer to the native people of South Africa. This term is also used as an umbrella term for the coloured, and Indian people of South Africa.

CHAPTER ONE

Introduction: A Government tool for child wellbeing

I am four years old, maybe already five. In the year 1989. I remember protesting. Kicking up dust, in the small village of Mpozisa near the Alice town of the Eastern Cape. I want to be left by myself in the two-room mud house for the day while everyone goes about their other calling business.² But my mother takes me to Makhulu [granny] Koyo. Makhulu looks after me for the day. I do not like Makhulu Koyo. 'Eat! Sit! Go pee! Sleep,' in such an order, or any! If she catches me climbing over the fence, she makes me drink a half of a coffee mug of ukrakrayo, a very bitter indigenous traditional laxative mixture. Makhulu Koyo first gave me ukrakrayo when I complained of a stomach ache. It is only when she realised that I could not stand the bitter taste in my mouth that she started using ukrakrayo as a punishment.

[Memories from the villages - 1989]

It is argued by a number of scholars that the first days of life, up to the age of five I was at the time, are crucial for child wellbeing and survival (Lee, 2008, and Hoffman, 2010). And, among child wellbeing scholars, there is consensus that the earliest period in a child's life is critical for adult health and population well-being. Walker (1992) defines 'well-being' as made up of the monitoring and the achievement of a satisfying psychological and physical environment in the early days for the child to live. In taking care of the monitoring of the child's health, the state, together with mothers and caregivers hold a complex space and time, to not only ensure survival of children, but their overall wellbeing.

As can be seen in my memories from the villages above, there are diverse healing methods in South Africa. For stomach ache, Makulu Koyo did not take me to the clinic. These methods are often influenced by the multi-layer, temporality, and subjectivity in the management of primary care, often linked to cost (Gehring, 2013). It is therefore important, using the RtHB as one of the technologies the state uses to make babies live, to make observations and get narratives from those tasked with the primary care of children.

Health promotion in South Africa is guided by the Constitution and the Freedom Charter. The Children's Rights part of the South African constitution states that no child caregivers are to, 'place at risk the child's well-being, education, physical or

² A number of scholars have written about the former Bantustans of the Eastern Cape and how in the 80s and in the 90s the areas still had no formal infrastructure (Bank, 1984; Ntsebeza, 2007; Makhulu, Buggenhagen and Jackson, 2010). Therefore, during the time I was young there was no formal crèches.

mental health or spiritual, moral or social development.’ (Robinson, 2009:49). Further, in the promotion of access to healthcare, South Africa subscribes to the Alma Ata’s emphasis on the provision of universal access, that, healthcare should not only be accessed by those who can afford it. While in caring for children health is a component of wellbeing, it is important to bring in the Alma Ata’s definition of ‘health care’. The Alma Ata³ definition of ‘health care’ addresses very crucial issues of ‘methods’, ‘technology’ and the ‘self’. It stresses the importance as:

...essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. (Alma Ata, 1978)

Therefore, the Alma Ata declaration, similarly as with the constitution of South Africa, encourages Primary Health Care (PHC) to promote ‘Health for All’, also through the use of technologies. Going forward, I refer to wellbeing as encompassing of health care as defined by the Alma Ata. Focusing on the state-provided medical wellbeing, written and writing technology in the RtHB, which is issued to mothers at the child’s birth, the dissertation considers the intersection of wellbeing, surveillance and child care in Masiphumelele, a neighbourhood of Cape Town, South Africa, and one of my homes.

I draw on my own experiences in the rural Eastern Cape reflexively to both place myself in the thesis and to draw out the similarities and differences in how health is conceptualised. While still in the Eastern Cape, I remember...

...my Vaseline smeared small ankles and calves collect dust on the lively footpath that negotiates izicithi – shrubs, triumphantly to the clinic. My mother holds my left hand. In it, I feel her heart.

Gu gu... gu... gu

The clinic is an ugly yellow slender building. A grass green Jojo tank on the left side catches with a straw from the grey roof. Three rooms are it. This clinic, andiyithandi - I do not like. It does not smell right. Antiseptic. Much like the hospital in town.

Inside, on the long hard bench omama ababini - two mothers, swaddle babies in their arms. One pulls out ibele elisekunene - her right breast. ‘I like her style, the lighter lines on her breast!’ I think to myself.

‘Sonwabiso Ngcowa makaze, - Sonwabiso Ngcowa may come,’ the nurse calls from the one room.

³ It was at a world conference held at Kazakhstan in 1978 where the agreement was reached by present World Health Organisation member nations that primary healthcare is crucial for the wellbeing of citizens of the various countries. (Declaration of Alma-Ata International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978, 2004)

Mama smiles after I get the needle, 'uzokuba nempilo mntanam - you will have health my child,' she says and thanks the lady in a white buttoned up cloth. Could I not just be left to be?

[Memories from the villages – about 1993/ 1994]

No, I could not! This indicated the imagination of a child's wellbeing as being linked to and managed by the state. However, the state does stress that it 'is not solely responsible for the well-being and development of children. We begin to see the interplay between the state and caregivers in my memory from the villages above, and this will be further discussed and shown in this dissertation. The government and parents hold concurrent responsibilities to realise children's rights.' (The Presidency, The Republic of South Africa, 2009:46).

Further, while still in the village, for the routine clinic visits aimed at my wellbeing, my mother had a white paper with green lines that folded into a 'Z' shape. It opened to an A4 page of information.⁴ This card meant that if I was taken to any health facility, the healthcare worker had, in a single view, the history of my height and weight growth. Therefore, central to the sustaining of the development of a child, which is not uncomplicated, was the critical development of thinking about the future through monitoring and documenting.

In this introduction chapter I start off by offering the background of the state Road to Health Card (RtHC), which was further developed into the RtH Booklet. I then describe the current RtHB that is printed by the South African Department of Health (DoH). By beginning with a description of the booklet rather than the more conventional start with people in a place, I draw attention initially to the state. The state is the source of this document. Before describing the respondents to state power, I attempt to show how the state thinks about wellbeing. This is followed by the discussion of the research question, which centres on the meaning of the booklet as a technology object from the observations made from the context of my chosen field site, Masiphumelele. I end off Chapter One by outlining the rest of the dissertation.

⁴ When my mother travelled with me from the villages to Langa, Cape Town late 1984 she forgot my RtHC. In *Appendix 1* is the 'Preschool Health Card' that was issued to us at the Langa Clinic. Between Langa Clinic and the clinic in the village in Alice my mother used this card together with my RtHC. When I visited the clinic again at the age of 11 years, I was issued with the Ceskei General Health Card by the clinic in the villages (See *Appendix 2*).

‘Road to Health Booklet’, a background

David Morley, renowned for innovations in the field of child health, came up with the RtHC. It was a specialised child development monitoring tool for the detection of signs of potential child death in West Africa in the 1950’s (Morley and Cuthbertson, 1962). Working in Nigeria, Morley focused on outpatient medical services for children under the age of five years. His focus was coming up with inexpensive methods to combat diseases such as malaria, measles, whooping cough, smallpox, and tuberculosis on children. Seen as a best tool to think about the status of children to their future lives in children’s medical care, the RtHC was widely adopted by different state health institutions in various countries in Africa. The RtHC was a card with graphs to plot the child’s weight and height growth. *Appendix 1* is one variation of the RtHC which was issued to me in 1984 by the then South African Health Department.

Heckman (2006) supported the use of the RtHC by observing that the first effective monitoring during infancy has been shown to be cost effective in offsetting future state expenditure on chronic diseases. There is evidently a high need to use inexpensive methods to manage wellbeing in Africa. This is in response to the finding made by a number of scholars, such as (Dawson and Jennings, 2012), that ‘public health should focus on who has the worst health’ (43). Kaseje also notes that the;

...poor are the most exposed to the risks of hazardous environments, and the least informed about threats to health. It is the poor who bear the brunt of crude Structural Adjustment Policies⁵, unregulated globalization, HIV/Aids epidemics, malaria, and tuberculosis. (2006:5).

Some of the findings made by Kaseje here, such as the impact of HIV/ Aids on the adult population in Africa have resulted in absolute poverty. The United Nations (UN) defined ‘absolute poverty’ as ‘a condition characterized by severe deprivation of basic human needs’ (U.N. World Summit for Social Development: Copenhagen, Denmark, March 6–12, 1995), and affects the productivities of economies. Therefore, many in Africa cannot afford the price of medical care. Inexpensive, but effective methods are therefore crucial to enhance the wellbeing of people in large numbers in Africa.

⁵ These were ‘undertaken with the purpose of regaining the growth path following internal and external shocks.’ (Balassa, 1982:23) in countries considered poor in Africa from the 1950’s. However, the results in many of the countries were more dependence on the West, the International Monetary Fund and the World Bank. Two things can be counted as part of the failures of these policies, and these are the high interest rates that were charged by the funders, and the corruption within the countries that were getting the ‘help’.

The Health Department in South Africa, much in need of the cost-effective methods of managing child wellbeing started making use of the RtHC in 1973 (Crisp and Donald, 1987). In these years, during and before apartheid, which was the segregation of the population based on skin colour, 'legally' from 1948 to 1994, health services were skewed towards white European descendants as policy of colonisation and apartheid. The multi layered healthcare provision system in South Africa, more so between the private and public healthcare systems results in sustained inequality in healthcare provision. Post democracy in 1994, there are persistent 'Disadvantages in education, work and housing all contributed to a profound inequality in physical well-being.' (Inwood and Masakure, 2013:63). The state attempted to reimagine the management of child welfare and population futures inclusively from 1994 when the democratic dispensation took over.

In 2011, the RtHC was revised, and further developed into a comprehensive child wellbeing program summarised in a booklet of 28 pages, the Road to Health Booklet. Van der Linde et al. note that in South Africa, the 'only nationally implemented developmental 'screening' tool' (2015:188) is the one found on the RtHB. Further, on why the booklet was introduced in South Africa was that it allows the South African state to meet some international child health obligations in the distribution of equal basic services for children. One of these is the Millennium Development Goals (MDGs), where child and maternal well-being are goals four and five. The MDGs were decided upon by the international community in 2000 and lasted until 2015. Nowadays the Sustainable Development Goals (SDGs) are the guiding framework for international development commitments. Again, child wellbeing, which the booklet allows the monitoring of, with a focus in the mortality rate is flagged an important issue.⁶

Moreover, on infant mortality, according to the Institute of Race Relations (IRR), there has been a marked decrease in child mortality rates in South Africa. The organisation attributes this to the improved child health in the country (2017). It found that the under-five mortality rate had declined from 77.2 deaths per 1000 live births in 2002 to 45.1 deaths per 1000 live births deaths in 2015.⁷ To indicate the severity of the issue in South Africa, I refer to a ranking released by Statista of the

⁶ The infant mortality rate (IMR) is the number of deaths of children under one year of age per 1000 live births (United Nations, 2003).

⁷ The institute also found that deaths of infants under one year of age declined from 51.2 deaths per 1000 live births in 2002 to 34.4 deaths per 1000 live births in 2015.

top 20 countries with the lowest child mortality rates. Monaco was number one, with 1.8 deaths per 1000 live births (Statista, 2019). South Africa is therefore coming off a low base, and, the improved rates of child mortality and morbidity indicated by the IRR in South Africa are still high compared to other parts of the world.

Promoting exclusive breastfeeding⁸ for the first six months, and monitoring the social wellbeing of children was the key component in the trial of the RtHB before full implementation in South Africa. After such trials by the health department, the revised version from the card to the RtHB became part of standard postnatal and infant care that covered a wider range of wellbeing elements. Minister of Health, Dr Aaron Motsoaledi, emphasised the importance of exclusively breastfeeding infants for six months at the ‘Tshwane Declaration of Support for Breastfeeding’⁹ in 2011. To further curb morbidities, further research shows that there is a seven-fold risk of contracting illnesses such as diarrhoea, and even death in infants of between the ages of 0–5 months if they are not breastfed (Black, Morris and Bryce, 2003).

Therefore, to address its commitment to infant and maternal well-being, and particularly to monitor and intervene in cases of stunting,¹⁰ the Western Cape Government health system initiated a programme on ‘First Thousand Days of Life’ in 2013. The Western Cape has vast difference in the experiences of people. There are those who are economically well secured, and those who are in dire situations of lacking basic needs. It is for partly this reason that the crucial approach in the ‘First Thousand Days of Life’ views the time during pregnancy up to the age of two years of a child’s life as a ‘critical window of opportunity’ in both the infant’s development and to secure the future health of the population (Department of Health, South Africa, 2013:4). Neurological development is also at its most intense in this stage. Though ‘The First Thousand Days’ is measured from conception up to two years, by ‘child’ here, I am referring to children under the age of five years. I use this

⁸ Exclusive breastfeeding means that the infant receives only breast milk. No other liquids or solids are given – not even water – with the exception of oral rehydration solutions, or drops/syrups of vitamins, minerals or medicines. (World Health Organization, 2018)

⁹ ‘...a breastfeeding consultative meeting took place in Tshwane in August 2011. The objectives were to build consensus on policy and programme changes to reflect new evidence on breastfeeding, including in the context of HIV & Aids, identify the critical next steps for South Africa to promote, protect and support breastfeeding as a key child survival strategy, and to mobilise support and commitment to promote, protect and support breastfeeding.’ (Gov.za, 2018)

¹⁰ Stunting’ is malnutrition that causes low ‘Height for age’ (Department of health, 2008). In the RtHB, stunting is ascertained by plotting a graph which is found between the 14th and the 16th page of the RtHB. Stunting is caused by a lack of vitamins or minerals, and nutritious foods. Semba and Bloem (2002), argued that stunting cannot be reversed in adulthood. Data, published on stunting in South Africa indicated that stunting for 0- to 3-year-olds is 26.5% (Casale, Desmond and Richter, 2014).

benchmark for the reason that Mosley, and Chen, (1984), argue that in an ideal setting, children should survive the first five years of life.

This booklet and its reception, as a material object, as an artefact of a particular way of thinking about health and futures, and as a mediator and indicator of social relations, is the subject of study in this dissertation. What does this booklet look and feel like?

The makeup of the RtHB

The booklet is issued at state health facilities free of charge in the child's name. It is intended to be managed by the mothers or caregivers. *Figure 1* below is the cover page of the booklet. It highlights the emphasised instruction to the mother or caregiver 'IMPORTANT: Always bring this booklet when you visit any health clinic, doctor or hospital.' (RtHB Cover Page, 2011).

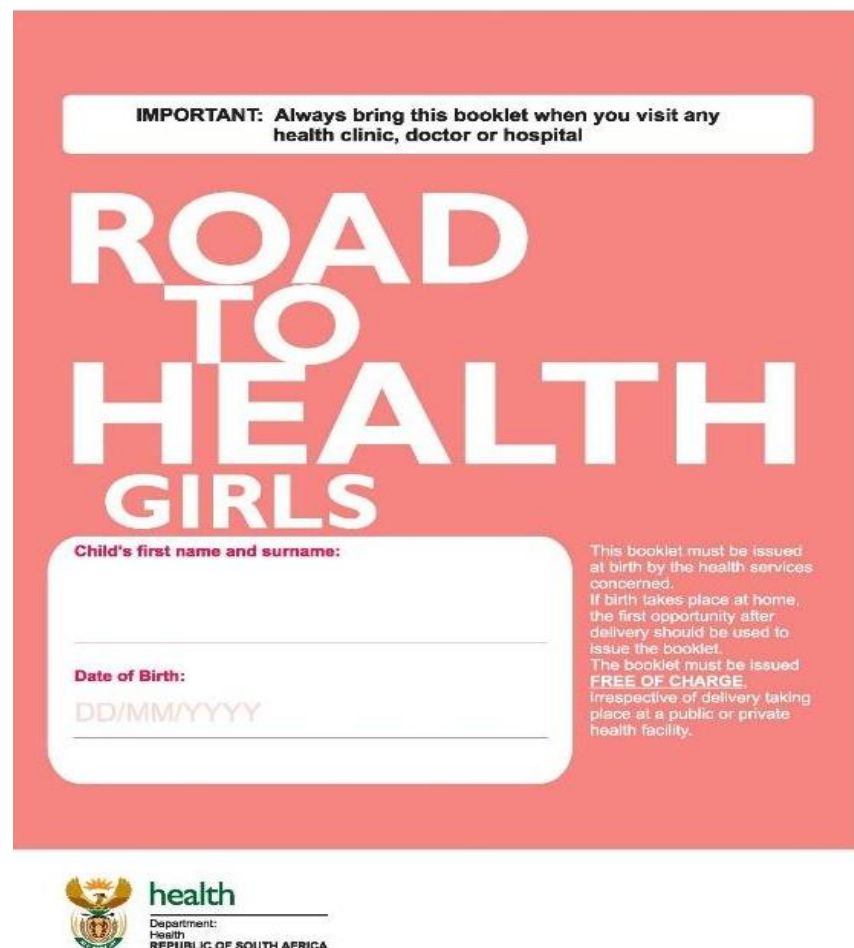


Figure 1: Front cover of the girls' RtHB

In a manner that suggests that the state in the issuing of this booklet conforms to the gendered ‘binary normalisation’, the pink one (as seen in *Figures 1 - 16*) is issued to girl children, and a green/ blue one to boys. The only difference in the content is in the weight and height graphs (see *Appendix 6 & 7*).

After I had done my field work and had started the writing process on the current RtHB, the South African Health Department started piloting a revised version of the booklet (see *Appendix 5*), which forms part of the South African Government National Development Plan 2030.¹¹ Having perused the 46 page piloted version and noted that it contributes to the same core child and mother monitoring aspects of keeping the child alive, and the gendering of childcare, I at times refer to it in this section. In parts below where I further introduce the booklet, I describe the additions as appropriate, but the bulk of the work rests on the currently used 28-page RtHB.

In the piloted version of the booklet, the boy and girl children get the same colour book. All printed books have both the boys’ and the girls’ ‘Height for Age’, followed by the ‘Weight for Height’ where nurses fill in one according to the child’s sex.

Figure 2 below is the second page of the booklet where dates of when the child is to be taken to the clinic are recorded. These are carried through to Page 3. These visits have a formal name: ‘Well-Child Visits’. Korsch (1971) notes that these are when mothers go to the clinic on the dates that are stipulated on the booklet for immunisations and advice on feeding. The framing of these days as ‘well child visits’ suggests the intention to encourage people to think proactively about wellbeing rather than reactively to illness. These therefore set in place a specific rhythm to childhood; the clinic visits are a way of counting time and inserting people into the time of the state.

¹¹ This plan is to eradicate poverty by the year 2030 in the country. One of the aims are that ‘In 2030, South Africa’s health system works for everyone. It provides quality care to all, has raised life expectancy to at least 70 years, produced a young generation largely free of HIV infection, and has dramatically reduced infant mortality.’ (Brand South Africa, 2019)

2

WELL CHILD VISITS – RECORDING SHEET FOR CHILDREN										
Record the following information for each visit on the spaces that are not shaded. Refer to the page numbers given in this booklet and complete the relevant section.						Remember to check the following. Tick if done, and record details on the relevant page				Date of next visit
Age	Date	Growth (IMCI) (page 14)	PMTCT/ HIV status (IMCI) (page 7&8)	TB status (IMCI)	Feeding (EBF/EFF/ mixed feeding for first 6 months)	Immunisations (page 6)	Vitamin A (page 9)	Deworming (page 9)	Development (page 13)	
3-6 days										
6 wks										
10 wks										
14 wks										
4 mths										
5 mths										
6 mths										
7 mths										
8 mths										
9 mths										
10 mths										

ROAD TO HEALTH

Figure 2: Well-Child Visits – Recording Sheet

In the piloted version of the booklet space for the ‘Well-child Visits’ information is provided in one page, on Page 2. And in this version, they are referred to as ‘Clinic Visits’. Before going to the ‘Clinic Visits’, a ‘Contents Page’ has also been added.

The fourth page of the booklet, as depicted in *Figure 3* below asks who the child lives with. This page also asks for the mother’s and father’s name and contact details. Carlson and Corcoran, 2001 observed that children have a relationship with the people around them in a way that affects their growth. They highlighted the achievement of a good ‘...family income, mother’s psychological functioning, and the quality of the home environment... (as) particularly important...’ (Carlson and Corcoran, 2001:779) for the positive growth of a child.

DETAILS OF CHILD AND FAMILY (To be completed at birth)	
Child's first name and surname: _____	
Child's ID number:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Mother's ID number:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Date of birth dd / mm / yyyy	Name of facility where child was born:
Child's residential address:	
Mother's name:	Mother's birth date:
Father's name:	Who does the child live with?
How many children has the mother had (including this child?)	
Number born (including stillbirths) <input type="text"/>	Reason(s) for death(s):
Number alive now <input type="text"/>	Date information given: dd / mm / yyyy
Child in need of special care (mark with X) (Complete at delivery or at first contact with health services)	
Is the baby a twin, triplet, etc? <input type="button" value="Yes"/> <input type="button" value="No"/>	Does the mother need additional support to care for the child? (Specify) <input type="button" value="Yes"/> <input type="button" value="No"/>
Any disability present (including birth defects?) (Specify) <input type="button" value="Yes"/> <input type="button" value="No"/>	Other: (Specify)
Stamp of facility and name and signature of official who issued booklet	

Figure 3: Details of Child and Family (To be completed at birth)

IMMUNISATIONS					
Name and surname:				ID number:	
				<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Age group	Batch no.	Vaccine	Site	Date given dd/mm/yy	Signature
Birth		BCG	Right arm		
		OPV0	Oral		
6 weeks		OPV1	Oral		
		RV1	Oral		
		DTaP-IPV-Hib1	Left thigh		
		Hep B1	Right thigh		
10 weeks		PCV 1	Right thigh		
		DTaP-IPV-Hib2	Left thigh		
		Hep B2	Right thigh		
14 weeks		DTaP-IPV-Hib3	Left thigh		
		Hep B3	Right thigh		
		PCV2	Right thigh		
9 months		RV2	Oral		
		Measles1	Left thigh		
18 months		PCV3	Right thigh		
		DTaP-IPV-Hib4	Left arm		
6 years		Measles2	Right arm		
12 years		Td	Left arm		

HEAD CIRCUMFERENCE AT 14 WEEKS AND AT 12 MONTHS	
14 Weeks: _____ (Range: 37 - 42 cm)	12 Months: _____ (Range: 42 - 47.5)
REFER if head circumference is outside range	

Figure 4: Immunisations

The booklet also records immunisations to be given to the child in Page 5 (*Figure 4 above*). These immunisations are discussed further in Chapter Six

The ‘Head Circumference at 14 and at 12 Months’ is taken on the child and also recorded on this page. Holden (2014) noted the non-invasive measuring of the head to be a crucial step towards understanding the child’s neurological development in order to intervene early should abnormalities that may lead to disabilities be noticed.

The ‘Neonatal Information’, as seen in *Figure 5* below, is recorded on Page 6 of the booklet. In the piloted version this page is called ‘Antenatal, birth and new-born history’, and it is on Page 38.

6

NEONATAL INFORMATION			
Birth weight:	Birth length:	Head circumference at birth:	
Gestational age (weeks)	Rh factor	Mother's RPR	
Antenatal (Maternal history):		Intrapartum (including mode of delivery)	
APGAR	1 min	5 min	
Neonatal problems: (identify high risk problems):			
Neonatal Feeding: <input type="checkbox"/> Exclusive breast <input type="checkbox"/> Exclusive formula			
Special care plan / input required (e.g. Kangaroo Mother Care)			
Specify:			
Post-discharge plan (if baby was admitted in a neonatal ward/premature):			

ROAD TO HEALTH

Figure 5: Neonatal Information

Figure 6 and *Figure 7* below make provision for the recording of HIV information for the mother and the child. The Prevention of Mother to Child Transmission (PMTCT) of HIV is detailed on Page 7 and 8. Page 8 is the continuation of the HIV testing and information.

The piloted version of the booklet does not make mention of PMTCT. It considers ‘HIV Exposure’, and provision for the latter is made on Page 38. This type of framing begins to neutralise potential stigma, which is further discussed in Chapter Four.

7

PMTCT/HIV INFORMATION	
Child's first name and surname: _____	
Child's ID Number:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Signature of consent: _____	
Date: _____	
Fill in this section on discharge from Midwife Obstetric Unit (MOU) or obstetric ward or at first subsequent visit if not yet done	
Mother's latest HIV test result	<input type="button" value="Positive"/> <input type="button" value="Negative"/> <input type="button" value="To be done"/>
When did mother have the test?	<input type="checkbox"/> Before pregnancy <input type="checkbox"/> During pregnancy <input type="checkbox"/> At delivery
Is the mother on life-long ART?	<input type="button" value="Yes"/> <input type="button" value="No"/>
If yes, duration of life-long ART at time of delivery	<input type="checkbox"/> < 4 weeks <input type="checkbox"/> > 4 weeks <input type="checkbox"/> Before pregnancy
Document ARVs the mother received:	
Did the mother receive infant feeding counseling?	<input type="button" value="Yes"/> <input type="button" value="No"/>
Decision about infant feeding	<input type="checkbox"/> Exclusive breast <input type="checkbox"/> Exclusive formula
Document Nevirapine given:	
All HIV exposed infants should receive Nevirapine for a minimum of 6 weeks	
Has the mother disclosed to anyone in the household?	<input type="button" value="Yes"/> <input type="button" value="No"/>
Has the mother's partner been tested?	<input type="button" value="Yes"/> <input type="button" value="No"/>
Remember to offer testing for all the mother's other children if not yet done	
Offer a mother with unknown HIV status a rapid HIV test. If mother's HIV rapid test is positive, perform an HIV DNA PCR test on infant if $\geq 6/52$	

Figure 6: PMTCT/HIV Information

8

Fill in this section if infant is HIV exposed	
6 week visit	
What feeds has the infant received?	<input type="checkbox"/> Exclusive breast <input type="checkbox"/> Exclusive formula <input type="checkbox"/> Mixed feeding
HIV PCR test done? Date:	<input type="button" value="Yes"/> <input type="button" value="No"/> Affix NHLS tracking barcoded sticker here
Cotrimoxazole started?	<input type="button" value="Yes"/> <input type="button" value="No"/>
Infant feeding discussed?	<input type="button" value="Yes"/> <input type="button" value="No"/>
Has the child received Nevirapine?	If yes: <input type="button" value="Stop now"/> <input type="button" value="Continue"/>
Stop Nevirapine if the mother is on life-long ART or the child has stopped breastfeeding. If not, continue until breastfeeding stops	
10 week visit, or earlier if ill	
PCR result	<input type="button" value="Positive"/> <input type="button" value="Negative"/>
Post test counseling done?	<input type="button" value="Yes"/> <input type="button" value="No"/>
Referred for ART?	<input type="button" value="Yes"/> <input type="button" value="No"/> Stop Nevirapine if PCR is positive
Cotrimoxazole given?	<input type="button" value="Yes"/> <input type="button" value="No"/>
Has child received Nevirapine?	If yes: <input type="button" value="Stop now"/> <input type="button" value="Continue"/>
Encourage a mother whose baby is HIV positive to continue breastfeeding	
Retest HIV negative children 6 weeks after cessation of breastfeeding, or if clinical suspicion. An HIV exposed child should be retested with a rapid HIV Antibody test at 18 months	
Repeat PCR test Date:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative HIV antibody test Date: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
Post test counseling done?	<input type="button" value="Yes"/> <input type="button" value="No"/>
Referred for ART	<input type="button" value="Yes"/> <input type="button" value="No"/> Stop Nevirapine if PCR is positive
Cotrimoxazole given?	<input type="button" value="Yes"/> <input type="button" value="No"/>
Has child received Nevirapine?	If yes: <input type="button" value="Stop now"/> <input type="button" value="Continue"/>
Tick if there is additional information on HIV status in clinical notes <input type="checkbox"/>	

Figure 7: Fill in this section if infant is HIV exposed

VITAMIN A SUPPLEMENTATION						
	At age	Date given dd/mm/yy	Signature	At age	Date given dd/mm/yy	Signature
100 000 IU	6 mths	/ /				
200 000 IU every 6 months	12 mths	/ /		42 mths	/ /	
	18 mths	/ /		48 mths	/ /	
	24 mths	/ /		54 mths	/ /	
	30 mths	/ /		60 mths	/ /	
	36 mths	/ /				
ADDITIONAL DOSES:						
For conditions such as measles, severe malnutrition, xerophthalmia and persistent diarrhoea. Omit if dose has been given in last month. Measles and xerophthalmia: Give one dose daily for two consecutive days. Record the reason and dose given below.						
Date	Dose given	Reason	Signature	Date	Dose given	Reason
DEWORMING TREATMENT (Mebendazole or Albendazole)						
Dose	At age	Date given dd/mm/yy	Signature	At age	Date given dd/mm/yy	Signature
	12 mths	/ /		18 mths	/ /	
	24 mths	/ /		48 mths	/ /	
	30 mths	/ /		54 mths	/ /	
	36 mths	/ /		60 mths	/ /	
	42 mths	/ /				

Figure 8: Vitamin A Supplementation


Figure 8 above is the ninth page of the booklet. 'Vitamin A Supplementation' and the 'Deworming Treatment' is recorded on this page. This information is also on one page of the piloted version, and it is on Page 28.

HEALTH PROMOTION MESSAGES

Up to 6 months

Feeding:

- Breastfeed **exclusively** (give infant only breast milk and no other liquids or solids, not even water, with exception of drops or syrup consisting of vitamins, mineral supplements or medication);
- Breastfeed as often as the child wants, day and night;
- Feed at least 8 to 12 times in 24 hours;
- When away from the child leave expressed breast milk to feed with a cup;
- Avoid using bottles or artificial teats (dummies) as this may interfere with suckling, be difficult to clean and may carry germs that can make your baby sick.



Why is exclusive breastfeeding important?

- Other foods or fluids may damage a young baby's gut and make it easy for infections (including HIV) to get into the baby's body;
- Decreases the risk of diarrhoea;
- It decreases risk of respiratory infections;
- It decreases risk of allergies;

If you have chosen to formula feed your baby, discuss safe preparation and use of formula with the health care worker

Play: Provide ways for your child to see, hear, feel, and move. Have colorful things to see and reach

Communicate: Look into your child's eyes and smile at him or her. Talk to your child and get a conversation going with sounds or gestures.





Figure 9: Health Promotion Messages

HEALTH PROMOTION MESSAGES

6 - 12 months


Feeding:

For all children start complementary foods at 6 months



- ♦ Continue breastfeeding;
- ♦ Always breastfeed first before giving complementary foods;
- ♦ Start giving 2—3 teaspoons of mashed dried beans and/or locally available animal foods daily to supplement the iron in the breastmilk. Examples include egg (yolk), minced meat, fish, chicken/chicken livers, mopani worms. Give soft porridge, vegetables and then fruit;
- ♦ Gradually increase the amount and frequency of feeds.
- ♦ Children between 6—8 months should have two meals a day. By 12 months this should have increased to 5 small meals per day, whilst frequent breastfeeding continues;
- ♦ Offer your baby safe, clean water regularly;
- ♦ If the baby is not breastfed, give formula or at least 2 cups of full cream cow's milk (cow's milk can be given from 9 months of age)

Play: Give your child clean household things to handle, bang and drop.



Communicate:

Respond to your child's sounds and interests. Tell your child the names of things and people.

Encourage feeding during illness Suggest an extra meal a day for a week after getting better

Feeding recommendation for DIARRHOEA

- ♦ Follow feeding recommendations for the child's age, but give small frequent meals (at least 6 times a day);
- ♦ Give a sugar-salt solution (SSS) in addition to feeds. Give SSS after each loose stool, using frequent small sips from a cup (half cup for children under 2 years and 1 cup for children 2—5 years). If the child vomits, wait for 10 minutes then continue, but more slowly

How to prepare a sugar-salt solution (SSS) at home




Figure 10: Health Promotion Messages

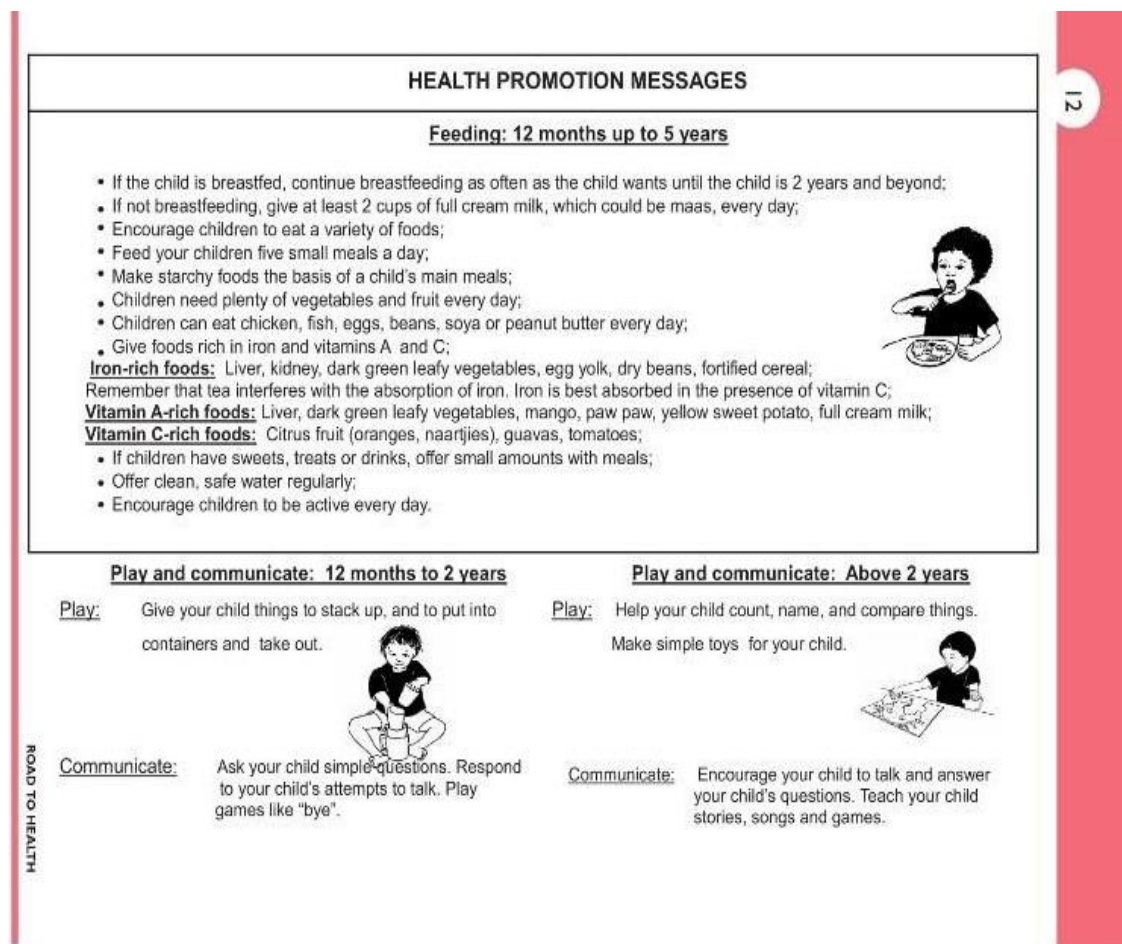







Figure 11: Health Promotion Messages

Figures 9,10 and 11 above show the 'Health Promotion Messages' covered on Pages 10, 11 and 12 of the booklet. These messages are aimed at the mothers and caregiver, suggesting that the state uses the booklet as a form of health education provision. Emphasis on child feeding, play and communicating is highlighted in this part of the booklet. Further, the state attempts to improve exclusive breastfeeding in line with scientific findings about its benefits and to meet the state's commitment to the Tshwane Declaration¹⁰ of 2011 described above. Therefore, the state is envisaging health in a much wider sense than just a physically healthy body.

¹⁰ In South Africa, up until 2006 HIV positive mothers were provided with formula as breastfeeding was seen as putting the children at risk of contracting HIV from the mothers. However, research findings have led to a policy change in the country. One message is given to all mothers now, regardless of their HIV status, and that is to exclusively breastfeed their children for at least the first six months of life. The Tshwane Declaration was used to spread this message as breastfeeding for the first six months helps towards the child's survival. (Department of Health - Province of Kwazulu Natal, 2014)

DEVELOPMENTAL SCREENING			
	VISION AND ADAPTIVE	HEARING AND COMMUNICATION	MOTOR DEVELOPMENT
ALWAYS ASK	Can your child see?	Can your child hear and communicate as other children?	Does your child do the same things as other children of the same age?
14 weeks	Baby follows close objects with eyes	Baby responds to sound by stopping sucking, blinking or turning	Child lifts head when held against shoulder 
6 months	Baby recognises familiar faces	Child turns head to look for sound	Child holds a toy in each hand 
9 months	Child's eyes focus on far objects Eyes move well together (No squint)	Child turns when called	Child sits and plays without support 
18 months	Child looks at small things and pictures	Child points to 3 simple objects Child uses at least 3 words other than names Child understands simple commands	Child walks well  Child uses fingers to feed
3 years	Sees small shapes clearly at 6 metres	Child speaks in simple 3 word sentences	Child runs well and climbs on things
5-6 years: School readiness	No problem with vision, use a Snellen E chart to check	Speaks in full sentences and interact with children and adults	Hops on one foot  Able to draw a stick person
REFER	Refer the child to the next level of care if child has not achieved the developmental milestone. Refer motor problem to Occupational Therapist/Physiotherapist and hearing and speech problem to Speech therapist/Audiologist if you have the services at your facilities.		

ROAD TO HEALTH

Figure 12: Developmental Screening

Figure 12, as seen above, Page 13 of the booklet deals with the child's 'Developmental Screening'. The last row on this page is significant because it directs the health practitioner to a series of next steps and a route to obtaining wellbeing through the health system. In the piloted version, the same title is used, however, in this version a signature of the healthcare worker and date is required as confirmation of each of the milestones.

Between pages 14 and 18, as seen in *Appendix 6* for girls, and *Appendix 7* for boys, the 'Height for Age' and the 'Weight for Height' graphs are available. Mosley & Chen (1984) made a comparison of height for age between South Africa and world standards, and, linking this to the socio-economic statuses of the children found that parental living arrangements, parental financial support, access to nutrition has a vast impact on the outcomes of the children's growth.

Figure 13 is Page 19 below where the ‘Mid-Upper Arm Circumference’ (MUAC) is recorded to detect and prevent malnutrition on children. Chaput et al, (2016) highlight that this measurement is a proxy for obesity. Highlighting that, ‘Childhood obesity is an important public health issue worldwide and has been associated with a wide range of adverse health risks’ (Chaput et al, 2016:1).

In the piloted version, a full page, Page 10, is dedicated to MUAC.

19

MID-UPPER ARM CIRCUMFERENCE (MUAC) (Every 3 months)							
Date of visit	MUAC	Date of visit	MUAC	Date of visit	MUAC	Date of visit	MUAC

< 11.5 cm indicates severe acute malnutrition (REFER urgently)
 ≥11.5 < 12.5 cm indicates moderate acute malnutrition (Manage as in IMCI guide-lines)

HOSPITAL ADMISSIONS				
Hospital name	Admission number	Date of admission dd/mm/yyyy	Date of discharge dd/mm/yyyy	Discharge diagnosis
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	

NAME OF CLINIC(S) VISITED	
Clinic 1:	Clinic 2:
Clinic 3:	Clinic 4:

ROAD TO HEALTH

Figure 13: ‘Mid-Upper Arm Circumference’ (MUAC) (Every three months)

Figure 14 covers ‘Oral Health Examination’. A clinical study done by Hargreaves et al., (1999) showed that 15% of children in South African communities showed primary teeth trauma.

In the piloted version, provision for ‘Oral Health’ is provided on Page 29.

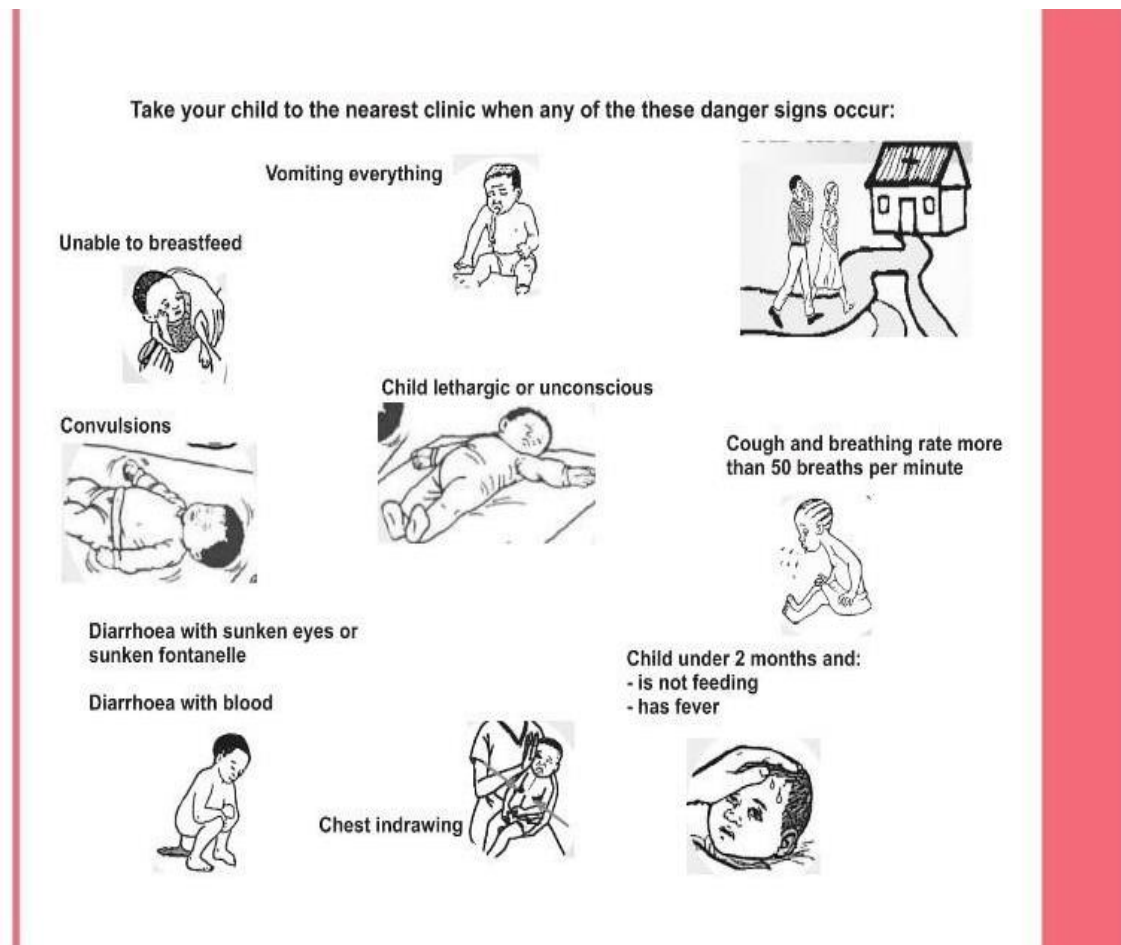


Figure 16: Take your child to the nearest clinic when any of these danger signs occur

Figure 16 is the back cover of the booklet, and it contains the ‘Danger Signs’. This is the same on the piloted version. These signs are for the caregiver to watch on a child to pick up an indication for medical attention.

The booklet therefore is intended as a way of using clinic attendance to implement health measures, such as vaccinations, to record child development using measurements in order to identify children at risk to initiate ‘pathways to care’, and finally, also as a pedagogic intervention in that it seeks to educate caregivers by both giving information in the interests of becoming active in health care provision.

The research question

I have described the RtHB in some detail above for two reasons. As the focus of my study, it was also my entry point into new relationships in Masiphumelele. This because, as far as I could ascertain, there has never been a study of the booklet from the mothers’ and caregivers’ points of view. There is little emphasis on the role of mothers or caregivers in the existing literature on the booklet; most studies focus on

healthcare workers' responses to the book and the information it contains (Kibel and Wagstaff, 2003; Harrison, 2010). Therefore, in this dissertation I ask, how do the mothers in Masiphumelele interpret the booklet as the state's endeavour to make infants and children live?

Drawing on recent anthropological interest in the social life of objects and in the materialities of objects, I am interested in understanding how the book represents ideas about health and how it materialises in social relations both inside health facilities and beyond the healthcare setting. My data for the former is drawn from interviews with caregivers, and for the latter from participant observation. Kopytoff argues that 'things' have 'biographies' (Kopytoff, 1986). And these biographies shape how things are understood and received in society. He therefore maintains that through recognising and interpreting the 'life' of an object, its value among people will be understood. It is particularly compelling to think about the life of an object that itself is a record of life. Therefore the RtHB is a site in itself. I ask: what significance does what the booklet records hold in the everyday realities of children, mothers and caregivers in Masiphumelele? How do the people who raise children understand and relate to the booklet?

Dissertation argument and chapter outline

I draw on Foucault's theory of 'governmentality', which is a modern form of 'pastoral power' in exploring the question that arose while probing the material for my research proposal. Briefly defined, 'pastoral power', is the benevolent care of the state influenced by Christianity (Foucault, 1982). Governmentality is the spectrum of awareness and intelligence aimed at supervising the self via the ruling of daily attitudes (Foucault, 1994). Foucault also maintains that 'Power is everywhere' (1994:93). Therefore, the subjects whose daily activities are ruled also have some power. I explore the power relations that the booklet materialises (or does not) among the mothers and caregivers in relation to the state in Masiphumelele. I argue that one of the things that the booklet does is that it helps manage the relationship of the timespan of wellbeing, the 'now' and the future. I argue further that the booklet is an artefact, or a technology of governance, used by the state as part of meeting its obligation to make children live, an aspect of 'pastoral' care. This booklet is much more than just a record of child wellbeing, as a form of 'governmentality', it is a referral tool as it is contextualised in

responding directly to HIV, child morbidity and mortality, and increasingly, to maternal well-being.

In Chapter Two I describe the process of designing and continuous redesigning of the methods of managing engagements and relationships while in the field. In this chapter I also reflect on doing research at home. Having reflected above on Dawson's (2011) and Keseje's (2006) notion that the poor are more vulnerable to health risks, and thinking about South Africa's adoption of the Alma Ata's Health For All principle, I argue that the people I engaged with in Masiphumelele are an important piece of the puzzle in the state's endeavour to make live.

In Chapter Three I grapple with 'pastoral power' and 'governmentality'. Before making the argument that 'pastoral power', in the instance of the RtHB is gendered, I first grapple with conditions that produce a subject of this kind of power. I argue that there is a reason why the state focuses on the socially inscribed gender role of the mother. For the biological fact that the mother's body, to an extent larger than that of the father, is attached to the infant after birth, the state then galvanises the mother to be a further agent of 'pastoral' care.

In Chapter Four I deliberately follow the booklet from the point the mothers receive it into the township. My argument in this chapter is two-fold. First, it is that the state has a comprehensive programme to manage HIV and Aids through the booklet. However, second is that the mentioning of the Mother and child's HIV status in the booklet does discourage the mothers from sending other caregivers to the health facility should they not be able to take their children themselves.

The argument I am making in Chapter Five is that in the state's envisaging of managing children's wellbeing as 'pastoral power', the state, through this booklet gives the mothers agency in the home environment. In the booklet, provision is made for the father's details. However, the mothers, have the final say on what goes in this booklet when it comes to the fathers of their children. For instance, in the booklet, the state defines the father as biological, whereas for the mothers, biological notions of relatedness are not sufficient. Mothers therefore act on this insufficiency.

In Chapter Six I grapple with the state's notion of what a 'well-child' is. I argue that the state highlights the importance of the child's environment, the periodic bringing back of the child to a health facility for check-ups and immunisations and supplementation where necessary as being key towards this definition. I demonstrate

the environment the children and mothers live in, further arguing that the state pre-empts some of the diseases that may be caused by unhygienic environments. Using the information required on the booklet, the state proactively acts to achieve making the child live.

In Chapter Seven I argue that in making the child live, the booklet as a technique, is, on the one hand, complemented by the indigenous knowledge that exists here, and on the other, conflicted by it. The booklet therefore does not substitute for indigenous knowledge, nor does it aim to do the latter.

Chapter Eight is the dissertation conclusion where I argue that though the booklet is not fully a pedagogical tool to the mothers, it is still effective as all the mothers had it and were responding to its primary objective, which is to get the child and mother periodically to a health facility. The mothers keep it as a link to the state as opposed to learning from it.

CHAPTER TWO

Customising learning about the ‘Road to Health Booklet’

Introduction, getting to know Masiphumelele

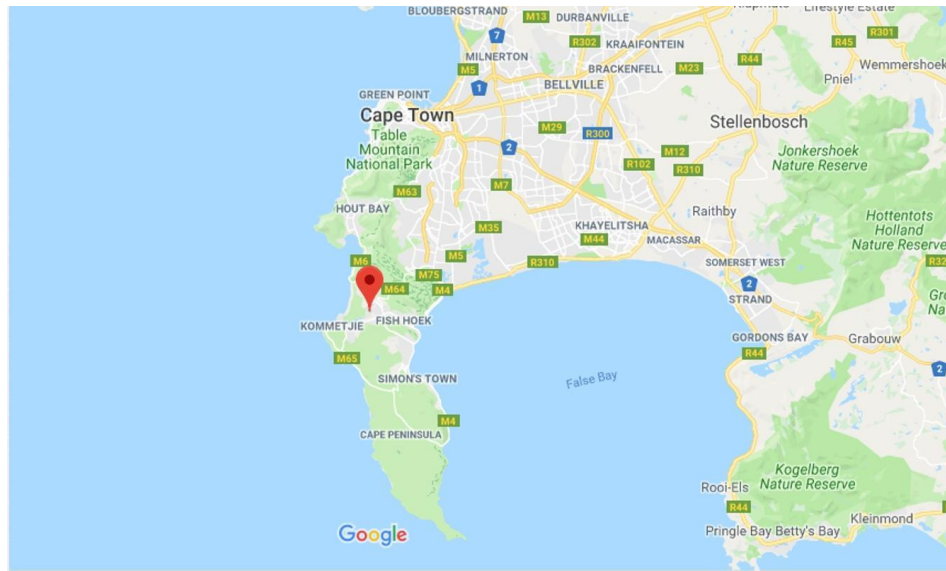


Figure 17: (Google Maps, 2018): Far Western Part of the Western Cape Province where Masiphumelele is situated.

Masiphumelele is 40.9 kilometres south of the Cape Town Central Business District, and, 36.6 kilometres from the Cape of Good Hope (Cape Point). Masiphumelele is a Xhosa word meaning ‘let us succeed’, which is perhaps an imagination, an illusion considering the measure of lack and health risks in the township. Bray et al (2010) noted that Masiphumelele was created in ‘1991 as a semi-formal settlement for the small number of Black African people already living in the Valley [in the South Peninsula of Cape Town], either legally or illegally.’ (1). The latter was as a result of overcrowding in the township Khayelitsha. To date, people still move to Masiphumelele from the Eastern Cape Province to access what is ‘perceived as better educational and employment opportunities’ (Bray and Brandt, 2005:4). My personal reflection in *Appendix 4* too speaks to the latter.

The violence and controversy of the apartheid state met this place with continuous forced removals of people and the demolishing of shacks. In Masiphumelele, people were often moved back to the Khayelitsha township which is more than thirty-five

kilometres away, regardless of whether they came from Khayelitsha or the Eastern Cape (Bray et al., 2010). In post-apartheid South Africa, the state continues to influence the existence and living of people through continued evictions and the demolishing of shacks erected by new and people who have been in Masiphumelele for many years (Kgatla, 2014). One of the many conflicts around rehousing residents of Masiphumelele has to do with the state saying that part of the area is a wetland and not appropriate for human habitation, and residents requiring land.



Figure 18 : Google Satellite Map of Masiphumelele (Red, blue, yellow and green lines added by the author) (Google Earth, 2018)

The area encircled with a green line at the top of the map (*see Figure 18*) is *Ezimbacwini*, which is the wetland part of Masiphumelele. Translated into English, *imbacu* means a refugee, and therefore, *Ezimbacwini* means a place of refugees. The people who settled in this section of Masiphumelele from Khayelitsha and the Eastern Cape referred to themselves as refugees. This is the part of Masiphumelele where people have limited access to water and sanitation. Unofficial electricity connections that are run on the ground also cross narrow informal walkways *Ezimbacwini*.

Marked in yellow in *Figure 18* is the *nyunyu* in *Figure 21* below close by where two of the mothers I worked with live. It is an approximately 4.5 metres wide creek, and runs for about 210 meters long through *Ezimbacwini*. It is black and green water with human excrements in parts.

The shacks in this area leak in the cold, winter rainy season. In most cases the shacks are not properly ventilated and therefore become stifling during hot summer months. In this context *Ezimbacwini* means destitution as well. People here live under the

constant threat or vulnerability to shack fires. This is one of the things I observed when I entered the field. Many in the overcrowded township make use of paraffin stoves to cook and or to provide the much-needed warmth during cold winter months.



Figure 19: Backyard and front yard shacks in Phase One, Masiphumelele

Masiphumelele has two sections with family residential houses built by the state with brick and mortar, Phase One and Phase Two as can be seen in *Figure 18*, the Google Earth photo of Masiphumelele which I have added lines on for illustration. Phase One and Phase Two are separated by the red line I have drawn in, with Phase One on the right of the photograph. In the built sections, on the small properties there are many shacks as people's houses wherever there is space (see *Figure 19*), which is a response to the experiences of poverty, that by such overcrowding increases health risks in this community. Residents with plots make a small income from renting out space in their yards. This is the result of the high unemployment rate of 23% (Stats SA, 2017) in Cape Town, and worse in the townships. With absolute poverty being a reality in Masiphumelele, the home owners received to own one and two-bedroom brick and mortar houses through fully funded government subsidies.



Figure 20: Communal toilets *Ezimbacwini*¹¹ (three boys kneel and wash their school shirts)

According to Statistics South Africa, males make up 53.26% of the population of Masiphumelele, with the females making up 46.74 (Stats SA, 2017). According to Masicorp, a nongovernmental organisation that promotes human development in Masiphumelele, the resident population is young: there is one child for every two adults (Masicorp.org, 2018), and suggests that there are 4000 children between the ages of zero to six years in the township. Such a high number of children existing in this small, in parts unhygienic space may result in diseases.

Mayosi and Benatar observed that post 1994, ‘the health and well-being of most South Africans remain plagued by a relentless burden of infectious and noncommunicable diseases’ (2014:1345). In this chapter I motivate, discussing the possible triggers of trauma and threats to children wellbeing that may exist here, why Masiphumelele is a useful site for a study of the presence of a patient held health record in the RtHB. Since 1994, Masiphumelele has seen a rising influx of people from the former Bantustans,¹² driven partly by the perception that health facilities are often better here than those in the villages. However, the urban infrastructure is not growing as fast as the migrations

¹¹ This is not an official name for the area. It is also referred to as Masiphumelele Wetlands.

¹² These were areas demarcated for black people of South Africa prior to and during apartheid. van der Merwe (2015) suggests that These ‘reserve armies of labour’ were not only for mining and agriculture’ (64).

are happening towards it, as a consequence, there is evidence of the burden of overcrowding and diseases.



Figure 21: *Inyunyu Ezimbacwini* (Children playing in a part of *inyunyu*)

In the community of Masiphumelele there is one clinic, as seen in *Figure 22*. Two private doctors operate in the township. One of these doctors charges a flat fee which includes consultation and medication of R200. The second doctor charges an amount of R350 for her services. These doctors have office hours of between 9am and 2pm. I also counted 33 places where either a traditional healer operated, or a church that offers *muti*¹³ for healing. The public hospital is in the suburb of Fish Hoek which is 4,5 kilometres away. In the same suburb is the Fish Hoek Clinic. In Masiphumelele there

¹³ This is a South African word for alternative medicines usually given by Traditional Healers.

are also churches and traditional healers which also come into play in the management of infant wellbeing. With such complexities, below I describe how I did research in Masiphumelele.



Figure 22: Masiphumelele Clinic

On methodology and selecting research participants

It is the year 2017 February. I am older now. I understand needles. I like that medical clinics exist. I appreciate nurses.

The University of Cape Town Anthropology Department tearoom overlooks the Cape Flats. I am now a Masters in Anthropology student. A group of us sit in a semicircle. Professor Fiona Ross talks about the First Thousand Days to us.

[Personal reflection]

The personal reflection above is from one of the meetings of the assembly of a small research team, where each member was looking at a different aspect of the relationships generated in early childhood. My project was to look at the relationship between infant and state, using the booklet as an entry point and as an indicator of 'how the state thinks'. From the discussions with Professor Ross, I arrive at the decision that the kind of data that I would look for is a combination of what people think about the booklet, and what people are doing with the booklet. I further was not just looking at the sociality of the object, but the object itself is the centre of my research. What happens to it? Where is it kept? Who may see it? Who may not? For what people are doing to manage early childhood, I aligned most of my fieldwork in the homes of children.

There were five key factors I looked for in relatability among the core focus people with who I needed to do my research. 1.) Geographical location - Reflecting on the

extensive research done by the United Nations (2003), which observed that under-five mortality rates are an indication of the social, economic and environmental conditions, I made the decision to work with mothers from both the areas of Masiphumelele, the formally built section (Phase One and Phase Two), and, *Ezimbacwini*. 2.) Child age - I looked for households who have children on or under the age of five years. The children in the households I targeted for my research did not have to be in the same age, but they all had to be under the age of five. 3.) Education - the third relatability I looked for was the level of education of the mothers and caregivers. Reich argues that 'Maternal knowledge of child development has been shown to affect how mothers raise their children and the environments they provide.' (2005:143). 4.) Income - Focusing on adolescent mothers of low-income status, Reich identified income as one of the key factors in managing a child's wellbeing (2005). 5.) Language - The booklet, especially being in a language that is different to what the mothers speak, requires some level of education to read it. Ramphele observed that;

Knowledge of language, idioms, customs and traditions and their distortions is an essential tool in tackling social questions, which leaves white social scientists, generally unfamiliar with black South African languages, at a disadvantage. (Ramphele, 2002: 22).

I therefore needed the mothers to be of mixed backgrounds.

After telling my friends about my coming fieldwork, one of my friends, Khaya, offered to introduce me to Gloria, a lady he knew who had done some work with mothers in the township before.¹⁴ Khaya set up our meeting at his work place. On the day I met Gloria for the first time, I invited her and my friend Khaya to Nongoloza's Braai Place, a popular meat *braaing* place in Masiphumelele. The two started giving me brief descriptions of the mothers. Gloria went through her phone and gave me some names. She also explained where the other households with mothers we could approach were. These are mothers Gloria and Khaya knew from the township. From this, I started a snowball sample of the possible mothers we could approach. On the following Saturday, I arranged to go with Gloria to the mothers we listed. On meeting the mothers, after agreeing to be part of my research, some kept referring us to other mothers they know. After approaching the households, the mothers, as further described in the following tables agreed to be part of my research. In *Table 1* and *Table 2* below are the eight mothers who became my primary participants.

¹⁴ All names in the thesis are pseudonyms.

Table 1 : Mother, the children and the father

Mother	Mother Age	Total Number of children mother has	Children between the ages of 0 – 5 years	Sex of the child between the ages of 0 – 5 years	Where the child under five years old is during the day	Relationship status with the child's father	Child's father's involvement
Ntosh	44	Three	One child – 2 years old	Girl	Crèche	In a relationship with the father of her last two children	- Partly financial support - father sees the children daily
Nompumelelo	37	Two	One child – 3 years old	Girl	Crèche	Is in a relationship with her children's father	- receives financial support - lives with children in the same house
Sive	35	Two	Twins – 5 years old	Boys	Crèche	She is not in a relationship with her children's father	- No financial support - Does not see the children
Xoliswa	28	One	One child – 2 years old	Girl	Looked after by a friend	Not in a relationship with the child's father	- No financial support - Does not see the child
Lihle	23	One	One child – 5 months old	Boy	Looks after her child	Not in a relationship with the child's father (learnt after my fieldwork that he wants a paternity test, 'a DNA' as it is known)	- No financial support - Does not see the child
Olona	22	One	One child – 5 years old	Girl	Crèche	Is in a relationship with the child's father	- No financial support - Sees child sometime
Siya	19	One	One child – 4 years old	Boy	Crèche	In a relationship with the baby's father	- No financial support - Sees child sometime
Xabisa	18	One	One child – 2 years old	Girl	Crèche	In a relationship with the baby's father	- at times child's father gets money from his parents to support child - tries to see child every second day

Table 2: Education, income and living arrangements

Mother	Education	Employment status	Source of income	Dwelling type	Number of people in the household
Ntosh	Dropped out – Grade 8	Employed	Domestic work employment – Social grants for three children	Shack Backyard renting	Ntosh lives with her three children
Nompumelelo	Dropped out – Grade 8	Unemployed	Baby father’s part-time employment – social grants for the two children	Shack <i>Ezimbacwini</i>	Nompumelelo lives with the father of her children and her two children
Sive	Dropped out after first year of tertiary	Employed	Employment - She chose not to answer the question if she was receiving a social grant for her children or not	Brick and mortar	Sive lives with her mother and her two children
Xoliswa	Dropped out after second year of tertiary	Employed	Employment and child social grant	shack <i>Ezimbacwini</i>	Xoliswa lives on her own with her child
Lihle	Dropped out – Grade 9	Unemployed	Lihle’s mother’s part-time domestic work income and the child’s social grant	Shack Backyard renting	Lihle lives with her mother and her child
Olona	Dropped out – Grade 10	Part-time	Olona’s part-time employment – her mother works as a domestic worker – father unemployed	Shack Backyard renting	Olona lives with her mother, her father and her child
Siya	Currently in Grade 10	School going	Siya’s brother is permanently employed – child social grant	Shack <i>Ezimbacwini</i>	Siya lives with her mother, her child, and older brother has a separate shack entrance
Xabisa	Currently in Grade 10	School going	Older sister’s employment – child social grant	Shack Backyard renting	Xabisa lives with her child and older sister – her mother was visiting during my fieldwork

All the mothers speak isiXhosa. Three of the mothers in my sample were in regular (albeit poorly paid) employment, and one works two days a week. Two have post matric education, however, they did not complete the courses they enrolled for. The high unemployment, school and university dropout rate is a micro view of the overall situation in Masiphumelele. Two are still in school and Two dropped out in Grade 8, one in Grade 9 and another in Grade 10. Five were in relationships with the fathers of their children, who played very little to no role in the household or in the children's lives. One mother lived with the father of her children. Five of the women lived with their mothers (grandmothers to the children in my research), and not with the fathers of their children.

Mayekiso observed that, 'In the public discourse, the current image of black fathers is that of an uncaring 'sperm donor', fathering children without care and abandoning the children's mothers, and even more disturbingly, as rapists.' (2017:16). He set out, studying the status of the father in Gugulethu in post-apartheid South Africa, Mayekiso (2017) in a quest to try and understand where these sentiments come from, highlighted the lack of relationships between children and their biological fathers. He found that due to unemployment, fathers had a limited ability to take financial responsibility for their children. This was partly due to the legacy of apartheid laws and its migrant labour policies, that also meant that some of the fathers themselves experienced the absence of their fathers (Mayekiso, 2017; Bray, 2010). Mayekiso further observed some of the maternal families to be playing gatekeeping if fathers did not meet the requirements of being a recognised father, as a challenge for fathers to be with their children. Therefore, Mayekiso agrees with other scholars who have studied fatherhood, that 'fatherhood, like motherhood, is a socially constructed category, greatly shaped by political, historical, as well as sociocultural environments.' (Mayekiso, 2017:66). With me being aware of some of the father child, father mother relationships, below I further discuss how doing research at home worked for me.

Home bound ethnography

In 1996 I was twelve years old when I moved from an Eastern Cape village to live in Masiphumelele. I speak the language and was socialised in the same culture as that of my research partners. In addition, like my research partners I was confronted with migrant labour, coming from a remote and very poor rural community to the townships and squatter camps of Cape Town. I know some of the traditional interpretations of

health and illness and curing approaches. See *Appendix 3* for an example of what some of the community members here are familiar with. This is an instance where biomedicine was used with indigenous knowledge.

In the year 2013 I left to be closer to the University of Cape Town for studies. Till argues that,

By moving between ever-changing homes/ fields and social relations, the researcher must acknowledge that research spaces are always hybrid; they are complex social spaces of dislocation. (2001:46)

I thought of the possible hybridity of activity and relationship interpretations in the place. One of these was my proximity to the mothers and children. Watching the news on television, and following some of the local news in Masiphumelele, with new expressions like ‘men are trash’¹⁴, as a response to the gender-based violence on women and children, I was concerned about how mothers may view me. Would they allow me, a man who ‘looks like’ the perpetrators of the gender-based violence they may have experienced or may have heard about in their intimate home spaces? Further, the mothers all confirming to be Xhosa, and, with a possible knowledge of the socialisation of a Xhosa man such as me, how would they receive me?

Becoming a Xhosa man is not only marked by age. Xhosa boys go through a rite of passage to be recognised as men. This rite of passage involves circumcision and spending time in the bush. During the time in the bush the initiate will be taught how to be a man. These teachings tend to re-emphasise a very patriarchal notion. They certainly discourage men doing what is viewed as feminine. The man is taught to be the head of the family. And, that responsible fatherhood is being able to provide food for the family. Nothing further to the involvement in the day to day raising of children.

Often elderly men in the village of Mpozisa where I grew up in the Eastern Cape, would say that a man is supposed to be in the kraal, and a woman is supposed to be in the kitchen. This means that a man is not supposed to occupy himself with ‘feminine activities’ like washing dishes and cooking, certainly, not changing child nappies and looking after infants and children. This is what Sz. Olah et. al. refer to as ‘male breadwinner-female homemaker’ point of view (Sz. Olah, Richter and Kotowska, 2014:21). There is a degree of change and these roles are becoming more and more blurred (Sz. Olah, Richter and Kotowska, 2014). Though there is this transition and

¹⁴ ‘men are trash’ is a hashtag, an expression on South Africa media platforms by mostly women as a response to the number of violent acts perpetrated by some men in South Africa on South African women.

transformation of roles (Doucet, 2018), the grandmothers to the children in my research remain conservative in this regard.

The mothers themselves did not raise questions about me, a man doing research on a document that is on children and women. It is the mothers' mothers (grandmothers to the children) who asked things such as, 'if you are not studying to be a [medical] doctor, why are you doing this work on children?', 'what are you going to do with the information?', 'do you like children?', 'do you have children?'. I often explained that my research will contribute to new knowledge about child and mother wellbeing. The replies from the grandmothers were often, 'oh, I'd like to see how that happens', or, 'so you do work with [medical] doctors.' These engagements suggested to me that the grandmothers to the children in my research, influenced by cultural norms, saw me, a man, as a person who could work with research on child wellbeing only if I am studying to be a medical doctor.

The mothers appeared to be made comfortable by the presence of Gloria and most of my fieldwork days. Though Gloria generally took a back seat when I was engaging with the mothers in her presence, some would look at her and nod while replying to any question I had during the fieldwork. Though the mothers were not verifying their replies to me with Gloria, I interpreted the nod to be acknowledgement of her presence. I make this observation further for the reason that on the few days I arrived in the mothers' homes without Gloria (whether coming late or not going to join me for the day), the mothers would immediately ask where she is.

Furthermore, on cultural norms and doing research at home, elderly men in Mpozisa argue that being addressed by *isiduko*, a clan name is one of the ways of showing respect to a Xhosa person. I found this in the field. At the beginning of my fieldwork I addressed the women I worked with as 'Sisi', a respectful way of addressing an older woman, and 'Mama', a respectful way of addressing a woman old enough to be one's mother. It was barely a week into my research that my participants and I were on first name basis, or *iziduko*, clan names, for some of the grandmothers. Sive's mother is Mamtolo. 'Ma-' is added in front of the clan name for a female.

Really, I am a niece in the Manywabeni clan. My mother's clan name is Magatyeni.

[Field notes]

The words above are from Sive's mother, Mamtolo when I shared with her that my clan name is Gatyeni. Mamtolo identified this as a genealogical connection between

her and me. Such clan affiliations are significant in consolidating types of relation in the township. Mamtolo opened up her home more to me, and about her relationship with her daughter Sive as a result of that latter. However, I did not regard Mamtolo as a family to me, but rather a research participant, or was, compared to other research participants, more of a friend. This friendship did not interfere with my main research participant, her daughter Sive. Further, in order to manage an ethical fieldwork, I needed to listen carefully about how mothers and caregivers capture their traditional environments in their local language.

Finding the mothers in language, and anonymity as ethics

The first discovery that I made is that the English in the RtHB is not the first language I have to be concerned about, but the different Xhosa dialects. During my research preparation and proposal writing, for the reason that I am Xhosa and would be doing research in a predominantly Xhosa township, I had not thought about language and the role it may play on how I position myself in the field. But, as Bernard notes, ‘Learning a new jargon in your own language is just as important as learning a foreign language.’ (Bernard, 1995:288). I first learned this by listening carefully to people’s reactions to how I described their homes. From acquired knowledge from conversations with people I have met about Xhosa dialects, a shack, among the Xhosa speaking people in Port Elizabeth is called *ibobosi*, in East London it is called *igali*. While the word commonly used among Xhosa people for a shack in Cape Town is *ityotyombe*, when I first got my shack at the back of the main family shack here in Masiphumelele, I called it *ikisti*. However, at the beginning of my research, referring to the structures some of my participants live in, I called a shack *indlu* (a house). I tried, to make my participants comfortable about where they live. However, this was often met with raised eyebrows. The way I thought I was dignifying my participants was making them feel like I was undermining their reality. This was best described by Siya when I referred to the shacks in *Ezimbacwini* as *izindlu* (houses), saying;

*No bhuti, this is a refugee place. We have already rebuilt our shack twice.
... Yes, I was born here in Masiphumelele. We have lost our shack in two
fires since I was born.*

[Field notes]

Siya rejected my description of her home, insisting that I recognise it as she experienced it. I therefore started using the words the mothers were using to describe their worlds as I realised that my use of different words was beginning to alienate me

from the mothers and how they saw their world. I continued paying attention to how people in Masiphumelele express their lives and context around the booklet.

On the expression of the practices to make a life, for Albert Schweitzer, German medical missionary, theologian, musician and philosopher, 'Ethics is nothing else than reverence for life.' (Tan and Tatsumura, 2014:351). I am guided by the Anthropology Southern Africa Ethical Guidelines (Anthropology Southern Africa, 2005), which stress the importance of the protection of personal information for research participants. An example of how I learnt about an aspect of the mothers' lives held in high regard happened while preparing my research proposal. It is in a time when I engaged with a young mother by the name of Shado. Early on, she drew my attention to the HIV-related notes in the booklet. Shado is HIV negative, but, when we discussed reasons why mothers would not want other people to see their booklet, she highlighted to me that as you flip open the booklet, the HIV status of the mother is recorded on the first page. I therefore became cautious. In consultation with my supervisor, we decided that I would not ask to see my participants' booklets unless they were offered. Instead, I made use of a printed blank document in discussions with mothers and caregivers. Though HIV came up in conversations and interviews with the mothers on the RtHB, I was therefore limited in knowing exactly who may have been HIV positive, and how those mothers negotiated this.

Discussions around HIV and Aids mostly came up in the structured interviews when I opened my blank RtHB to pages 7 and 8 where the booklet focuses on the HIV information of the mother and child. As the document is not an object of everyday use, and therefore not necessarily available through ordinary participant observation, I conducted semi-structured interviews with participants to reflect on its role in their lives. These were arranged towards the end of my fieldwork, once I was more familiar with caregivers and their relationships and they were comfortable discussing questions of health and social well-being with me. In the interviews done in the participant's homes, the main question was kept to one. I did not prepare a list of interview questions to follow. I rather wanted a conversation that would stem from my one opening question. With the aid of my blank RtHB, '*Yintoni lena* - what is this?' Follow up questions and a discussion would then be guided by the response of the mothers to this question. These are further discussed in Chapter Four.

Further, to ensure that I limit what may be a disruption to life here, particularly around HIV and Aids, one of my obligations while in the field and writing was anonymity. In my dissertation, I use pseudonyms for all my participants. When I discussed anonymity with my participants, I immediately saw how they valued their privacy. Xoliswa said,

Yes, these kids will grow up and attend the same universities. What would they say if they came across their names or the names of their mothers in those research papers?

[Field notes]

This response prompted two reactions from me; firstly, I emphasised that absolute anonymity cannot be guaranteed. Xoliswa asked me how, and what I mean by that. I explained that the possibility of people working out by putting information together who some of the participants are. However, I assured her that when writing I would write in a way that protects information about where my participants work, go to school, or if they do not work, or exactly where they live. And, that I would present information in a way that does not give directions to who they are.

My research respondents to the state produced document in the RtHB are the mothers. See *Appendix 8¹⁵* for the consent forms the mothers as my research participants signed. Other than doing some playful activities with the children, I did not seek responses about the RtHB from the children who can already talk. Secondly, as seen above, Xoliswa reminded me how not being careful with anonymity could infringe, not only on their immediate rights, but the imagined futures of their children as well. For this reason I have been very careful not to disclose individual information recorded in the booklet.

Conclusion, gatekeeping to me, and holding produced knowledge

Being part of the ‘sociocultural environment’ in Masiphumelele contributed towards gatekeeping. Till notes that a gatekeeper is someone who ‘provide(s) physical access to place and the people’ (2001:48). Reflecting in hindsight, on what Gloria was doing during the times she was introducing me to the mothers, I now see how she was handing part of the gatekeeping to me. Gloria started doing this by saying things like, ‘Do you know him. He is from here.’ Thereafter, the mothers gave me their cell phone numbers and during my fieldwork, I would be the one telling Gloria where we would need to be at what time.

¹⁵ In anticipation of the fact that some, most, or all of the mothers I would be working with would be Xhosa, I prepared a translated (into IsiXhosa) version of my consent form. Seven of the mothers opted to read and sign the English version. One mother, Ntosh, read and signed the Xhosa version.

Thinking about the reality, also captured by Gloria, that I am from the place, my main concern around my methodology has been managing confidentiality, and at the same time learn as much as possible about the state's power. The booklet had begun to show me that the state has the power to document people, the power to produce knowledge, the power to hold that information and the power to request mothers and caregivers to hold that information in the booklet. Therefore, researching about this state produced document, I looked for a literature framework that would assist me in situating the state in Masiphumelele through this booklet. As discussed above, the physical geography of the field was prior to my fieldwork partly known to me. The literature in the next chapter also helped me unlearn and relearn Masiphumelele.

CHAPTER THREE

State, ‘Pastoral Power’ and ‘Governmentality’

Introduction, state power over people

‘Pastoral power’, exemplified by Foucault, is the state as the shepherd leading his flock in his population or citizens (Foucault, 1982). Foucault argues that the state is an example of the institutions established on the foundations of Christianity that influenced ‘pastoral power’. Foucault maintains that the purpose of the state with this legitimised power is to make its citizens better people, and to protect its people from future harm (Foucault, 1982). And, Foucault argues that governmentality is one of the methods of discharging ‘pastoral power’. In this chapter I argue that, the RtHB, in managing the well-being of the individual in a place, and second, that of a population, is a tool of state ‘pastoral’ care and governmentality. I do this by first grappling with ‘pastoral power’, looking at the conditions that make ‘pastoral power’ possible. I conclude by looking at how ‘pastoral’ care in the instance of this booklet is gendered.

‘Pastoral power’, a cajoling style of governing

Foucault maintains that ‘pastoral power’ can be viewed as a shift from a penal form of power to a gaze from within. Part of the disadvantage of the penal power is that it limits the agency of those ruled. This form of power is taxing both for the ruler and the ruled. An excess amount of power is needed to maintain it. ‘Pastoral power’, on the other hand, is a relaxed form of power where the shepherd ‘speaks to his flock’ and encourages them to a path they must lead. Further, Foucault by a gaze from within is referring to the embodiment of this form of power by its subjects. Influenced by the way Christianity manages social networks, Foucault argues that ‘pastoral power’ became less and less confined to the religious bodies of the West, but extended to other institutions in society.

The state, as one of the institutions that use ‘pastoral power’, mandates itself with the priestly safeguarding of the population (Foucault, 1982). The state in this way puts itself at the top of the hierarchy in the management of the wellbeing of its citizens. The weighted priorities that must be protected are identified by the state. One of these priorities is wellbeing. By using its tools to keep a watch over what may threaten its power, the state’s ‘pastoral power’ therefore in this way remains intact. Foucault’s notion here is further best illustrated by the use of medical records, from the birth of a

person until the end of their life, by state healthcare institutions. As in the booklet, the state manages the producing and compiling of these, where third parties are not allowed to view without legally approved consent. The state therefore makes its power, and informed decisions on the population wellbeing using information on these documents.

On population consciousness, Dean (1999) suggests, that ‘pastoral power’ is also concerned with how individuals can control themselves. This self-control is encouraged by the state to prepare a healthy population not to be a drain on the fiscus and to be prepared for future work. The state therefore places certain responsibilities of wellbeing back to the individual. This is in line with Rose’s argument of ‘responsibilisation’. Rose (2000) defines ‘responsibilisation’ as a way of governing that encourages individual ‘prudence’. By this he asserts that individuals in society are more and more required to manage their own, and families’ futures. Rose further argues wellbeing is achieved in ‘responsibilisation’ in multiplicity of settings in politics and practicality. The latter is also what Douglas refers to as the ‘two bodies’ of the social and physical (Douglas, 2004). Therefore, ‘pastoral power’ encourages the physical body to control itself within the social body.

Therefore, the fluidity allowed by ‘pastoral power’ in this regard suggests that bodies can be social. It is not only the state that determines the future of the body, but wellbeing is a matter of socialisation too. Also, see *Appendix 4* for an illustration of how language captures the sociality of bodies. Rose’s and Douglas’ arguments of ‘responsibilisation’ and the ‘two bodies’ tie in well with the argument that I make throughout this dissertation, that the state, through this booklet empowers the mothers in managing the wellbeing and making live of their children now, and for future in the two identified bodies.

The state therefore has set objectives in the use of the booklet. Dean (2010) argues that the population has become the ‘object and objective’ of the state. Thinking about the population as an object of the state, it is the state with its ‘pastoral power’ that highlights the benefits of individuals taking care of their wellbeing as Foucault further observes that, the state’s power is ‘uncontrolled power over people’s bodies, their health, and their life and death.’ (1982:780). It is with the understanding that in order to have healthy families, the overall population must be protected from diseases, and vice versa. However, there have been competing views on the management of

populations, with some scholars arguing that population growth resulted in poverty (Ehrlich, 1995). It is after the United Nations international conference on population and development held in Cairo in 1994 (Boesten, 2010), that a specific change towards state policies was expressed and the growing wisdom of states to encourage individuals in a state to also see to their well-being. Even if only by keeping the relationships with the state.

How then does the state display benevolent wisdom in managing ‘pastoral’ care of the population and individual subsistence? Dean captures governmentality as a quest to know, ‘...by what means, mechanisms, procedures, instruments, tactics, techniques, technologies and vocabularies is authority constituted and rule accomplished?’ (2010:42). The state makes available structures, machinery and tools to manage the protection of citizens from harm (Foucault, 1982; Pearson, 2010). One of the tools that are used to maintain ‘pastoral power’ is documenting citizens. Through ‘pastoral power’ then, citizens are encouraged to work closely with words written by the state, to know what is best for themselves, and thereafter encouraged to behave in a manner that will maintain this. Key to this is the training of ‘officials or experts to create environments that first provide them with access to each citizen’s conscience and subsequently, to shape these consciences according to particular ends’ (McCuaig, Öhman and Wright, 2013:22). The officials are tasked with the work of accountability and management of state machinery, with limited discretion. The state therefore views health in personal terms, looking at the particular trajectory of a particular child, but also in normative terms, where the child is measured against the norms of height and weight for age.

Dean defines the target of ‘pastoral power’ as ‘...a being who is both obedient and needful’ (2010:93). A needful person can be defined as a person who is at risk of falling outside of the calculated anthropometric measures. Through research the state has designed anthropometric theories for minimising anomalies in human life. Anthropometry, a human body measurement mode in Anthropology is defined as:

...the use of (human) body measurements such as weight, height and mid upper arm circumference (MUAC), in combination with age and sex, to gauge growth or failure to grow. (UNICEF, 2011).

Scientists have discovered that certain body measurements stand as good proxies for particular aspects of health. For instance, MUAC is a good indicator of

malnourishment in young people and adults. Height for weight charts, adjusted to population, are good indicators for young children and babies.

Therefore, under the umbrella of ‘pastoral power’, governmentality is one of the mechanisms used to disseminate the produce of state power. Foucault holds that governmentality is ‘institutions, procedures, analyses and reflections, the calculations and tactics’ towards a production of power (Burchell, Gordon and Miller, 1991:102). Governmentality and wellbeing, Gupta further alludes that, ‘governmentality is about a concern with the population, with its health, longevity, productivity and size.’ (Gupta, 2012:151). The concern Gupta is referring to here is that of taking the state’s ‘pastoral power’ to the people. Sade (2012), building on the notions of Foucault and Gupta above continues to link governmentality to health by stating ‘that health care is an entitlement that must be provided by society and that obtaining health care is the responsibility of individuals.’ (286).

What if the individuals are new-borns who cannot yet have a meaningful engagement with the state? An attempt to answer the latter may be found in Huemer’s observation that,

... question is whether the government has certain special rights that you and I do not have and whether we have certain special duties to the government that we do not have towards anyone else. (Huemer, 2013:18)

An initial special right the state affords itself is that of knowing the child. The state does this through the provision of the RtHB, and in other specific ways: through the health and education systems and to a far lesser extent through the welfare and prison systems. The state knows the child as a person to cure, to educate, to care for and to punish and reform. In relation to health, the modern state, and especially the state that is invested in the child both as an individual potentially in need of healing or care and also as a member of a population in Foucault’s sense, an entity over which power is exerted. In relation to the latter, the state is increasingly being called to be invested in early childhood to offset later ill health in the individual and in the population at large; including in intervening in children’s lives now to secure the wellbeing of the population yet to come. However, the version of the state in the RtHB stands in contradistinction to an earlier version of documenting people under apartheid.

While the intentions of ‘pastoral power’ have been positive, South Africa provides an instance where the power of the state has not been beneficial to the greater population. Breckenridge (1998) has argued that documentation can be a form of epistemic

violence where the state has used documenting to violate people's dignity. This is certainly true of apartheid South Africa's pass laws and the accompanying *dompas*, however, it is not inevitably the case that all state certification constitutes violence. The booklet stands as one mode through which the state makes live. It is important to bring up the example of the *dompas* for comparing and contrasting purposes. Both the *dompas* and the RtHB are a means of documenting people by the state. The *dompas* took away from the dignity of black people. Breckenridge observed that the state 'needed' to know its members for 'capricious policing, mass arrest and imprisonment.' (2014:157).

The RtHB is a tool that is used to give dignity to all people within the state. The use of this booklet is a deliberate benevolent approach to ensure proper health care of the population. The state aims to, through making and managing individual person and population connectedness to it, to ensure individual well-being and protection against accidents (Pearson, 2010). The document is used as a means to identify populations at risk and to intervene to produce health. It is therefore a symbol of the state's intention and acknowledgement that a '...well designed growth study is a powerful tool with which to monitor the health of a population...' (Eveleth and Tanner, 1976:1). Further, in post-apartheid South Africa, an important institution that oversees the management of the population health is the constitution. Section 27 of the country's constitution states that 'Every person has the right to have access to health care services, including reproductive health care' (South Africa, 1997). In the following discussion and conclusion I argue that the RtHB focuses on the mother and child.

Discussion and conclusion, a gendered way of 'pastoral' care

The booklet identifies conspicuously two actors that are to be moulded into conceivable and imaginative subjects to influence. These are the child and the mother. The booklet is the first document of 'pastoral' care and governmentality that a child receives. In the booklet the state hosts, both physically and metaphorically these bodies. It is the child and the mother, the mother being the person expected to respond to its requirements.

A number of scholars have observed gender to be reinforcing the 'patriarchal claim [which] is that women are naturally subject to me [the man]...' (Pateman, 1988:225). Further, Gender can work on an elusive level, 'where images of masculinity and femininity impart meaning' (Sevenhuijsen, 1998:81). These meanings separate neutral

roles into distinct gender norms. Examples of these are found in division of household labour and caring for children. The way state institutions are accessed is characterised by gender norms, and 'gender is produced and maintained by identifiable social processes and built into the general social structure and individual identities' (Hirschmann, 2003:78). Through the booklet, the state disrupts this skewed socially constructed foundation of power. The document is not gender neutral. As it is usually men who have more access to the state, with this booklet, the state turns this notion upside down. But is it possible to achieve gender neutrality with the booklet, after removing the biological dictates of giving birth and breastfeeding the child? Rather than treating gender as difference, maybe the question should be, what of the roles in the booklet the mother, as well as the father can do?

Though Foucault does not engage deeply with the gendered nature of 'pastoral power', he does mention that 'the state becomes the patriarchal pastor protecting his flock.' (1982). Or, as Hirschmann suggests, the state becomes a second father, of the child when he is absent means that 'pastoral power' is gendered as masculine (2002). This means that the mother does not completely escape from patriarchy as a result of the use of the booklet by the state. The booklet reemphasises the role of the mother in raising a child.

With the biological possibility of breastfeeding subtracted, Kittay (1999) is convinced that there is nothing men cannot do in the work of raising and looking after children. Kittay maintains that the caring for children in a family ends up becoming the work of mothers or women. She argues that instead of referring to the work of raising children, there should be a move away from these gendered terms of 'mothering' and fathering, and instead refer to a neutral term 'dependency worker'. Opening up the term would be best as the idea of a patriarchal nuclear family as the only model of family is dissolving (Hirschmann, 2002). Further, Silva and Grace McInnes (1996) highlight that priority in social welfare is given to the mother. They see the mother as one who takes up the social responsibility of raising a child, with the expectations that the mother's autonomy in the raising of children should be more than that of the father. Therefore, though not encouraged by the state, the way the booklet is positioned suggests that a mother can be without the child's father in a welfare system. In the booklet the state positions motherhood as, even if the father is absent, a role that should

be done with the state. Lupton, (2011) argues that the state puts the mother at the centre in the promotion of child wellbeing.

The state creates heightened expectations of what it is to be a good mother. Here looking at the mother in a nuclear (as in a nuclear family). It is a mother with time, energy and resources. From the state's perspective, a responsible mother is an information seeker. A mother responsive to the maternal knowledge produced by the state. With the booklet, the state is therefore suggestive of a specific mother. A person in a role that should be saved, and the person herself to be saved and steered to safe mothering. It is a sufficient mother who makes antenatal and postnatal visits to a health system. The World Health Report of 2005 concluded that all mothers count in the management of child wellbeing. It also stressed that all mothers matter and that they need to be looked after through well-informed action (Högberg, 2005). The state wants the mother to use itself as a source of information, and an information retainer. In the following chapters I attempt to find out, using the booklet, if the state found this mother in Masiphumelele.

CHAPTER FOUR

‘I would not want people to know that I am sick.’ The secret document

Introduction, the state fights HIV

One of the critical issues that the state is concerned about is curbing vertical HIV transmissions. The state's intention is best captured in Hugh Masekela's song, 'Thuma Mina' (Send Me) which the current South African state leader, President Cyril Ramaphosa has adopted as a campaign of the state to take governing and government to the people (Maluleke, 2019). Masekela sings,

*I wanna be there when the people start to turn it around
When they triumph over poverty
I wanna be there when the people win the battle against AIDS*

(YouTube, 2019 Hugh Masekela song Thuma Mina)

The South African state has been 'singing this song in relation to HIV and Aids'. The cost of Aids has not only been monetary. It has also been paid by a severe loss of life of mothers, fathers, caregivers, and children whose full potential had not blossomed. As HIV is now considered a chronic disease, the state through the booklet allows for a space where it can be treated as preventable. HIV prevention no longer only focuses on preventing sexual transmission of the disease. This led to the development and medical advances of the 'Prevention of Mother to Child Transmission'.

Recommendations from the Health department of South Africa are that pregnant women first get tested within fourteen weeks of pregnancy. Should the mother test positive during pregnancy, on giving birth the booklet will be updated with the words, 'HIV Exposed' (Department of Health, South Africa, 2009:14). In order to protect the child, pregnant women are encouraged to take antiretroviral medication. Both these indications of the HIV status are viewed negatively by the mothers. Bodkin et al., also noted that 'Abandonment of HIV positive pregnant women by their partners, friends and families is not unexpected due to stigma and fear associated with an HIV positive diagnosis.' (Bodkin, Kloppe and Langley, 2006:739). Mothers therefore try to avoid the social stigmatisation that may come with their HIV status discovered through the booklet. The argument I make in this chapter is that mothers were not comfortable for the RtH booklet to be seen by other people, therefore making the booklet sacred. The

latter caused challenges when the children needed to be taken to 'well-child visits'. However, mothers showed willingness to discuss their statuses with the state.

A shack fire incident prompted me to start my fieldwork a few days earlier. I start with the fire incident to demonstrate that the state does not allow for a disconnection of the child and mother from itself. I wanted to see what the role of the state would be in this event and if any of the state's role could be linked to the booklet. This fire helped me observe and illustrate that the booklet is a document that is seen as important, and compulsory by the mother for the child.

Entering the field through the fire

A few days before the day I had set to start my fieldwork, I greeted Xoliswa on WhatsApp. I needed to make a final confirmation that myself, together with Gloria, we would be with Boniswa, the woman whom Xoliswa takes her child to, to be looked after when she needs to be at work, three days from then, and, later with her on her return on days she would be at work. Later in the evening she replied via a WhatsApp phone message:

'Yho bhuti kutshile apha - Brother there has been a fire here,' she writes. 'Oh no, is everyone okay?' I write back. I can see that she is typing a reply to me, but I decide to dial her number and speak to her on the phone instead. (ring)... (ring)... (ring)... (ring)... (ring)... (ring)... Sis'Xoliswa... bamba iphone. Ubuonline ngok' ngoku njena, Sisi Xoliswa - pick up the phone. You were online just now.

(ring)... (ring)... (ring)...

Xoliswa: Hello... hello bhuti

Sonwabiso: Hello, hello Sis'Xoliswa.

Xoliswa: Hello bhuti kuyangxolwa ke apha kugcwele - Hello Bhuti, it is noisy here there are a lot of people.

Sonwabiso: Ninjani Sisi? Akonzakelanga mntu? - How are you Sisi? Did anyone get injured?

Xoliswa: Hayi Bhuti. - No Bhuti.

Sonwabiso: Indlu yakho injani Sisi? - How is your house Sisi?

Xoliswa: Yho Bhuti ngentlahla awufikanga apha kum. - Bhuti by luck it didn't reach my house.

Sonwabiso: Uqale njani lomlilo Sisi? - How did the fire start Sisi?

Xoliswa: Asiyazi Bhuti. Ndifowunelwe ndisemsebnzini mna ndabuya. Kodwa uqale ngakulacross inqumla enyunywini. - We don't know. I was called at work and came back. But it started near the crossing that goes over enyunwini.

[Field notes]

Xoliswa tells me that she phoned Boniswa, to find out if her child and she were okay. Boniswa is the woman that looks after Xoliswa's child when she is at work. They were safe. She then rushed home to find that her shack had not burnt. Fortunately, the wind seemed to have changed direction, and the firefighters had arrived, therefore the fire

did not reach her shack.¹⁶ Boniswa, who was not as lucky, had been to the Long Beach Shopping Mall on foot with Xoliswa's daughter *embelekile* (on her back).¹⁷ When she came back, her shack was being gobbled up by high bright orange flames. She only remained with the clothes she had on left as her belongings. Xoliswa kept her daughter's RtHB in her child's bag. This bag also contains nappies, an extra set of her daughter's clothing, and the baby's porridge. During the day when Xoliswa is at work, the bag is with Boniswa. In her child's bag is generally where Xoliswa keeps her child's booklet. She also did this because if her daughter needed any medical attention Boniswa would be able to take her with the booklet to a health facility. Xoliswa's child's booklet burnt in that shack fire.

The fire incident is a best example to see how the state may use 'pastoral power' here. The state came in the form of the department of the City of Cape Town and delivered new material for people to rebuild their shacks. The state also came forth in the form of the Health Department with firefighters and paramedics. Going with Xoliswa and Boniswa a few times to the local community hall where other assistance was made available to the people after the fire by other non-government organisations, there were talks of the Department of Home Affairs coming. The department had not come by the time that the activity at the community hall subsided after four days. I asked Xoliswa if she had met, or heard of other mothers who may have lost their RtHBs in the fire, and what their plans were. Xoliswa and Boniswa highlighted that what people were crying for was their identity documents.

But, seeing that there was no provision for the reissuing of the RtHB at the community hall which was the meeting point to disburse the state's assistance, what process did Xoliswa have to follow to get a new booklet? At the False Bay Hospital Xoliswa was advised that she needs to go to the police station, complete an affidavit that says what happened to her child's booklet, and, with her identity book, completed affidavit, and the child's birth certificate she could get a new booklet at the clinic in Masiphumelele. However, it would be at the False Bay hospital where she eventually gets a new booklet. By the end of my fieldwork she still kept the blank RtHB. Xoliswa was talking about going to the clinic to find out when her next child's date is. But because she had taken off work a few times, I realised that she was not planning to go soonest. On

¹⁶ The fire station that services Masiphumelele is situated in Fish Hoek, which is 5,7 Kilometres away.

¹⁷ The mall is 3.8 kilometres from Masiphumelele.

reading further on the issuing of new RtHBs, I learnt that the clinic or hospital where the child was being treated could, from the child's folder update the booklet. I further wanted to make observations around how and when the mothers would have received the booklets. And with the new knowledge that Xoliswa kept her daughter's booklet in her child's bag, where do the rest of the mothers keep it?

Receiving the RtHB, a booklet unseen in the home

Xoliswa received her child's booklet from False Bay Hospital on the day she was discharged after giving birth. The rest of the mothers, except for Siya and Xabisa, also received their booklets from False Bay Hospital on the day they were each discharged. Siya was offered the booklet on the third day after she had delivered her son. The third day is the day she was also being discharged from the maternity ward in Mowbray Maternity clinic. On following up with Siya to find out why she gave birth at the Mowbray Maternity Hospital, and not False Bay Hospital, which is the hospital closest to Masiphumelele, she explained to me that she needed to get a caesarean, and False Bay Hospital does not perform these. Xabisa also received the booklet on the third day at the same Mowbray Maternity Hospital where she too got a caesarean.

The mothers highlighted that the nurses stressed that they should bring the booklet every time they go to the clinic with their children. With Siya, the nurse took time to explain the danger signs on the back of the booklet. Even with the cordial treatment by the nurses and doctors at the Mowbray Maternity Clinic, Siya did not ask further questions about the booklet when it was given to her.

I just took it with the hope that my mother will assist me [with understanding the RtHB]. She had done this [giving birth] a number of times before me.

[Field notes]

After the mothers received the RtHB, I wanted to find out where the booklet resides in the home. A key finding here was that this space is defined and owned by the mother. Therefore, as observed above, the booklet reproduces a mother's responsibility in raising children. Upon probing further about the choices of places where the mothers keep the booklet, majority of them made it clear that they were not comfortable with their children's booklets being easily accessible to other people as they did not want people to know theirs and their children's medical history. In the 'other people', the mothers were suggesting that the fathers are kept far from the booklet that they did not even feature in the conversation I had with mothers about where the booklet is kept.

Ntosh keeps her important documents with her employer.

*I keep important stuff at my work. My employers do not have a problem.
It is them who said I can bring them after we had the fire here.*

[Field notes]

Xabisa keeps her child's RtHB under her mattress. Sive too, has a Flip File that she keeps in her room under her mattress. In this Flip File is her Matric certificate, her identity book, her driver's learners license and her twin boys' booklets. Sive has some books that she keeps on top of the cabinet in her bedroom. When I asked Sive why she keeps her children's booklets under her mattress she shared that one day when she has her own house, where her bedroom will be her bedroom only, and that when her bedroom does not double as a visiting room anymore, she may put her future children's booklets anywhere in her bedroom. At the moment, she spends a lot of time with her friends and some visitors in her room. We were sitting in that room at that moment as her mother was receiving people in the sitting area of their house.

Siya keeps hers in her clothing suitcase. Olona keeps her child's RtHB in her clothing cupboard with her identity book and her daughter's birth certificate.

Lihle, talking about where she keeps the booklet said,

you know, we keep important things in my mother's wardrobe behind her clothes. If they were to break into our house while we sleep, they would just open my mother's side of the wardrobe and see that there are no name brands and just close it again.

[Field notes]

Mothers therefore are also guarding information. Foucault maintains that one of the strengths of 'pastoral power' is to know the individual's innermost secrets (1982). My observation here is supported by Foucault's argument that only the state has this power. Women do not allow other people to come into contact with the booklet. I became curious about the reasons for the latter and dedicated more time during my fieldwork to making more observations about this. Findings about this were largely around the uneasiness of the mothers to have their and their children's medical information known by other people in the family and community.

Fear of being stigmatised for known positive HIV status

In the booklet, for HIV negative mothers at the time of testing the doctors or nurses write 'HIV Unlikely' rather than 'HIV Negative' (Department of Health, South Africa, 2009:14). The HIV Unlikely refers to the infant, and that they are not likely to get HIV as at the time of testing the mother is testing negative. The reason the status is recorded

as 'unlikely' rather than 'negative' is to allow both for the possibility that testing has occurred in the 'window period' and that future infection may occur. To protect the infant, follow up tests are done periodically on the infant.

I observed how the RtHB interprets HIV, versus how the disease is treated in the community, which would be one of the reasons for the document being secret. In the booklet there is no mention of Aids. It is HIV that is written in it. However, the mothers I engaged with referred to the status indicated in the booklet as Aids. The mothers were not differentiating between the virus and the syndrome. The mothers understand the booklet to be referring to Aids. 'Hayi mna andinokufuna abantu bayazi ukuba ndiyagula.' (No I would not want people to know that I am sick.), Olona said when we were discussing the mentioning of the HIV status in the booklet. Though Olona confirmed that this part was filled in the booklet, she was not confirming if she did or did not have HIV, and all the mothers said it was completed, with the exception of Xoliswa, indicated that they were not entirely happy with other people seeing this.

Talking with Olona about the booklet, she indicated that the 'HIV Unlikely' annotation does not explicitly state that the mother does not have HIV. For her, she believes it is vague for the mothers, caregivers and those who may have access to the booklet. It means that the mother could still be HIV positive. The 'HIV Exposed' is certainly the one that mothers dread. Among the mothers, there was a general understanding of the importance of having the HIV test done for themselves and their children. Their concern with the recording of their HIV status on the booklet was around the implications of this status seen by other people in their environment.

Olona showed me that the transparency and openness with which the state treats HIV through the booklet does not support relationships between mothers, caregivers and those who may see the booklet in the community. However, this makes it more complex as the HIV information on the booklet is crucial for the state's management and prevention of the further spread of the disease. The mentioning of the HIV status made it difficult for the mothers to send other caregivers to the 'well-child visits' if they were not available. What does it mean to be stigmatised in the community of Masiphumelele? People who are known to have the HIV virus are shunned. Kruger et al. also observes this and states that, 'Much stigma is still associated with HIV/AIDS in many parts of Africa' (Kruger, Ndebele and Horn, 2014:96).

Conclusion, HIV stigma persists

The RtHB contains information that is deemed 'private' or likely to result in stigmatising, giving the booklet a sacred quality. It is kept away from others and treated in particular ways. It is not an ordinary piece of paper but, precisely because it discloses what is usually considered to be private, blurring the public and private space and creating a very particular relation between the women and the state. The mothers, with the exception of Nompumelelo and Lihle, used the Masiphumelele clinic. However, the mothers who used the Masiphumelele clinic expressed their wish to use the Fish Hoek clinic. The reasons for the latter were generally around the concern that other people from the community may get to know their and their children's health matters. However, a return taxi fare to the Fish Hoek clinic is R20.00, and the mothers feared that some months they would not be able to afford the fare.

There has been much work in South Africa to try to counter stigma over the last 30 years, but it persists. Having the HIV virus is often associated with the assumption of promiscuity. And, in a place where poverty is rife, networking is very important. Therefore, the risk of any slightest stigma closes these beneficial linkage channels. These beneficial linkages range from children being able to, and accepted to, play with other children. The mother's association with local groups like *stokvels*, which are groups that save money together, may be affected if the mother's HIV status is known. Friendship activities of borrowing each other's clothes do not happen with HIV positive people. Food and grocery sharing may also be impacted. Mothers therefore ensure the confidentiality of their statuses by not discussing the booklet, not even with the fathers of their children.

The narratives around the mothers receiving the booklet earlier in this chapter led me to the critical issue of the fathers which I deliberately wanted to make observations about. As the mothers were sharing with me about the times they received the booklet, I noticed that in all their narratives, the fathers of their children were all not present at the hospital when the mothers gave birth, and in these instances where the booklets were issued. It therefore was important for me to know more about, not only if the father is recorded in the booklet or not, but also what the fathers' involvement has been in the raising of children in the children's and the mothers' homes.

CHAPTER FIVE

‘So, it’s like I made this child alone.’ Fathers not in the RtHB

Introduction, child wellbeing is managed in a social structure

Helman argues that it is crucial to understand patient narratives within a cultural context. He adds that, in ‘the study of culture it is also necessary to examine the social organization of health...’ (Helman, 2007:7). Winkelman (2013) builds on this by observing that health is affected by wider cultural and personal issues that are not covered in Western medicine. The state empowers the mother with the RtHB in the network of ‘social organization of health’ around making the child live. In this chapter I argue that, while the booklet carries the state’s understanding of the relationships around the child, in the booklet, the father is defined differently to how the mothers perceive a child’s father. Therefore, there is a difference between the way the state understands relationships and the way the mothers do in Masiphumelele. I attempted to understand from the mothers if the fathers of their children are recorded in the booklet, as the booklet asks for it. The finding has been that the mothers do not automatically register their children’s father’s names in the booklet, accepting a biological relation of the child and father to be enough. For the mothers, there are responsibilities the father has to step up to in order to earn being added in the booklet. Thinking about Helman’s notion of ‘social organization of health’, I look to capture the makeup of the mothers’ networks. A brief background of the family in South Africa begins to help me understand this institution as it is here and now.

A dominant perspective in discourse suggests that during apartheid, black women within a family structure may have suffered the most (M’kumbuzi, Ibsen and Halvorsen, 2015). Scholars noted a dual exploitation of women in, first the apartheid system, and secondly, by the patriarchal black men while trying to see to the livelihoods of their children. M’kumbuzi, et al., argued that;

they [women] remained minors under the law, and were kept under the control of husbands, in-laws and chiefs, with few rights to own land or property. (2015:101).

This is especially true even in post-apartheid South Africa as mothers and caregivers themselves negotiate belonging, in what is deemed a family, and the state. For instance, if the picture of a family includes a father or not. None of the mothers

confirmed to have deliberately chosen to raise their children without the children's fathers under the same roof. Therefore, it is circumstances that led to the mothers raising their children without the children's fathers.

Moreover, many studies have shown how the child's life may be made better by the presence of the father in the home (Jarret, 1994; Desmond and Desmond, 2006). This means that the father is present to provide emotional and at times financial support to both the mother and the child. South Africa rates lowest in the continent when it comes to the presence of the fathers in the children's lives and home (Posel & Devey, 2006). Ramphela (2002) attributes this to the high unemployment rates in South Africa, particularly among black men due to apartheid and its legacy, that causes fathers to feel that they cannot provide for their families. I further continue below looking at the social networks around the child, focusing on the mothers' responses about the fathers of their children to argue that the RtHB empowers women in a patriarchal 'social organization of health', therefore making it an object that influences culture.

'As long as I would not be giving my children away.'

In *Figure 3*, which is the 4th page of the booklet, the state asks for the 'Father's name'. The mothers in my research said this part was not filled in their booklet. I sought to find out why the name of the father was not filled in the child's booklet. All of the fathers to the children in my research are living but, not all are fully involved in their children's lives. For Ntosh, the father of her first child, and her current boyfriend and father of her last two children may only have their names together with hers in any document only when '*ese into ekhaya*' (he has taken something to my home), Ntosh said. Ntosh here is referring to *intlawulo*. *Intlawulo* is a Xhosa word which literally means *payment*. In this context, the same word is used and its meaning changes to *a fine*. When an unmarried Xhosa girl or woman gets pregnant, *intlawulo*, payment for 'damages' is expected from the child's father for getting her pregnant.

Patel and Mavungu note that *intlawulo* as penalty payments are towards restoring relations 'for having offended and disrespected the female partner's family by impregnating her out-of-wedlock.' (2016:30). The damages payment is supposed to be used for the wellbeing of the child. This payment is determined by the child's mother's family. It is usually a cow, or in monetary value an amount that is equivalent to a cow value. Nowadays, a cow can cost anything from R5000.00 to R13000.00. The payment for damages is not a substitute for maintaining the child until he or she is an adult. The

damages payment is a sign of respect and acknowledgement that the father made the girl or woman pregnant and is not marrying her, or at least, not at this stage. If this payment is not made, some families will prevent the child's father from seeing his child until this payment is made. Without this, the fathers must just continue supporting the children. And, without the *intlawulo* made, the father cannot give the child his surname or clan name.

Sive shared with me that when she fell pregnant, she was taken to her then boyfriend's house. Her boyfriend's family said they would see after the child is born if indeed is their son's. She felt that her boyfriend at the time should have protected her and told his family that for sure that the baby is his.

He just kept quiet. That made me feel dirty you know, as if I sleep around... Before my babies were born, he [baby's father] moved to another township, to Delft. He was not working but I heard he became a music DJ. Eight months after my boys were born his family came with him and made a lot of promises. It has been five years now and I have not seen them again. These are not his children. I will not put his name anywhere.

[Field notes]

When Sive says, 'These are not his children...' she means that she no longer recognises his role or rights because he has failed to live up to the social compact. The social compact is first that of acknowledging, not just to Sive but to his parents also that he admits being the father of the children. Secondly, he had to pay the damages and demonstrate support to Sive.

On a different day,

I also found Lihle upset. The father of her child has just left her house. Her mother is also furious. He wanted to see his child. But he and his family have not paid intlawulo - the damages, forgetting Lihle pregnant. His family said they would come back after they were told the number of cows they would need to pay in rand value. It has been four months now and they brought nothing.

[Field notes]

Sive and Lihle therefore did not deem the fathers to their children fit to be added in their RtHBs. I continued wanting to know if the fathers are written on the children's RtHBs. Siya told me that,

I take my child to see his father sometimes. My mother and brother do not like it that I do that. So, I will lie and say I am going to my friend's. And, I go meet his father, so they could spend the short time. But when it comes to any documents, I make sure his name is not anywhere. I will do this until him and his family pay the damages.

Nompumelelo's child's father is also not in the booklet.

Nompumelelo: No. He is the father yes, but these are my children. He did not pay damages to my family, so the children are using my surname and all that. You know I had not really thought of that. There is no denying that he is the father. Now that you ask, maybe I would put his name in my child's clinic card [RtHB]. As long as I would not be giving my children away.

[Interview, 2017]

By 'As long as I would not be giving my children away' Nompumelelo means that by recognising him in the book she will be affording him rights that he has not yet earned because he has not stepped up to the responsibility he owes her family.

Fatherhood is a performance

Fathers cannot afford to fulfil *intlawulo* and end up being absent from the children's lives. Spiegel observed a concept called 'domestic fluidity' (Spiegel, 1996:5). The scarceness of employment as a means for financial security in the townships forces people to be scattered. This has led to the geographically stretched households. Such households meet the characteristics of the concept of 'domestic fluidity' (Spiegel, 1996). Children, mothers and fathers, because of these reasons shift between households in different locations. Though 'domestic fluidity' has some positive impacts on children, such as the benefits of getting to know different, extended family members, there are some negatives. Bray et al. observe that, 'children's well-being was severely compromised not so much by adult departures but by the lack of consistent parenting' (Bray, Gooskens, Kahn, Moses, Seekings, 2010:80). One way in which the state acknowledges this in the booklet is in how it is stressed that if the mother is not available, they should send a caregiver with the child and the booklet to a health facility. The state therefore understands the health of a child to be a collaborative effort between the mother and other caregivers. All the mothers confirmed that the fathers never took the children on their own to health facilities.

Furthermore, the country's background begins to help me understand the predicament many black fathers find themselves in in Masiphumelele. The discrimination of black people has led to many of the young men to be unemployed in South Africa. For many black young men in South Africa, paying *intlawulo*, the damages payment for making a girl pregnant is becoming a more and more impossible expectation. Mavangu et al., referring to the fathers in a study done in Johannesburg, South Africa noted that

‘Culturally, it is as if they [fathers] do not exist...’ (2013:25). This highlights that the fathers who cannot afford the damages fine causes hindrance to these father’s access to their children (Khewu and Adu, 2015; Nathane-Taulela and Nduna, 2015; Patel and Mavungu, 2016; Mayekiso, 2017).

I further begin to see what the state tool of ‘pastoral power’ in the RtHB does when it enters the home and the environment of the mother and child. State expectations often undergo transformations in local contexts (Tsing, 2005), influenced by certain histories, cultural and religious beliefs. The booklet, as a record of health held by the mothers is treated with some suspicion as adding the father’s name might bestow rights that the mothers are not yet ready to offer. But, does the gendered nature of this form of ‘pastoral power’ work in the favour of mothers in the relationship the child, mother and the child’s father are supposed to have with the state? If the fathers are not part of the booklet, how do the mothers negotiate taking to child the clinic should they not be available?

The state encourages the making of the child live to be managed jointly between the mother, the father and the caregivers who may be present in the child’s home environment. Mothers agree with the state that fathers need to step up in order to make the child live. However, by leaving the fathers out of the RtHB, the mothers are expressing the void. Xoliswa said in an interview when I asked her why her child’s father’s name is not in the RtHB,

Xoliswa: Why should I? He does not even know which way the door to the clinic is facing. When I was pregnant, I went alone to the hospital. Even on days he had time he did not want to come. So, it’s like I made this child alone.

[Interview, 2017]

Xoliswa’s words, ‘So, it’s like I made this child alone’ highlight the failure of the fathers in the mothers’ eyes and culturally, to be part of the ‘social organisation of health’ Helman (2007) referred to.

Fathers in my research did not know where the mothers keep the booklet as they never asked about this booklet. The mothers, by not adding the father’s name to the booklet are telling the state that, figuratively, they made, and continue to make the children live on their own. I have shown the latter to be largely due to the high unemployment as a result of apartheid. Additionally, tradition has its own importance, however, in this instance, it tended to restrain the relationship between the fathers and children

where fathers had not made the *intlawulo*, the damages payment. *Intlawulo* is patriarchal (Khewu and Adu, 2015; Patel and Mavungu, 2016). One of the reasons for this view is that it is the man who pays the damages, suggesting that mother could not have been capable of ‘damaging’ herself. The booklet empowers the mothers in that the mothers therefore have a say on *intlawulo* through the booklet.

As observed above, the relationship the mothers have with the fathers to their children is complex. The fact that they decide whether to add, or not add their names on the RtHB as fathers to their children symbolises the empowerment the booklet affords the mothers. There is therefore difference in how the booklet defines the father, versus, how the mothers do. The family structure has been destabilised, even decimated, historically. The booklet is suggestive of the state’s normative understanding of kinship, in which relationship is measured biologically. The booklet defines the father as biological, whereas for the mothers, a biological relation is not enough. Fatherhood is also a performance of the specific roles indicated above after the child is born. Because of the damages payment not having been made, the mothers have a different definition of a father to that of the state. However, the provision of the space for the father’s name in the booklet speaks to the state’s characteristic of ‘pastoral power’, which part of is to encourage well-functioning families for the benefit of the child as well as the population.

Conclusion’ the state’s ‘pastoral care’ clashes with *intlawulo*

Mothers are in a dilemma. They ‘cannot’ ask the fathers of their children to take the children to ‘well-child visits’. The state requires mothers to return to health facilities for a total number of twenty-seven times between birth and the age of twelve years. However, the mothers who had children older than ten months confirmed that activity in the booklet was in the first page of the ‘well-child visits’ section which is on Pages 2 (see *Figure 2* in Chapter One) and continued on Page 3 of the RtHB. In the first page visits up to the tenth month are recorded, suggesting that ‘well-child visits’ are not fully adhered to after the child is ten months. In these ten months, mothers have to negotiate ten ‘well-child visits’ to a health. This averages out to about once every month.

Siya confirmed that she missed school each time she had to take her child for ‘well-child visits’. Ntosh told me that, ‘I always made a plan’. It is Xoliswa who has asked the person who looks after her child while she is at work to take her child for one ‘well-

child visit' when she was unable to take off from work to do this. The mothers shared that when they missed a 'well-child visits' they would have to endure comments from the nurses like, 'What kind of mother are you?', implying that they are not good mothers and that they are endangering the lives of their children. This suggested that their own moralities are put on the line as a result of the ways that the state makes live. Ntosh was the exception. When she could not get off from work to take her child to some 'well-child visits', she went at a different date. Though the nurses or doctors would ask, she shared that they were not too strict about the dates. She still went within a month from the date indicated on the booklet as the next clinic date.

As seen a from the evidence above, the fathers do not assist the mothers with the management of the children's wellbeing around the booklet. This further suggests that women are evaluated based on whether they fulfil social expectations of a kind of mothering that itself is affirmed on a socio-cultural pattern. The social expectation observed here is that the mothers are to do it, on their own with the state. The next chapter deals further with the importance of the mothers to keep the relationship between their children, themselves and the state for their children's wellbeing.

CHAPTER SIX

‘We are breathing dirt here.’ State proactivity



Figure 23: Woman throwing contents of a pail in *inyunyu*.
(Accountability, 2018)



Figure 24: Concrete and wood crossing *Ezimbacwini*

Introduction, living next to *inyunyu*, a threat to a well child

In this chapter I zone in on the state's notion of a 'well-child'. Through the RtHB, the state defines a child as someone who is vulnerable. It further defines a child as a person who needs the periodic visits to a health facility for check-ups and immunisations and supplementation where necessary. I first describe findings on the children's and mothers' environments. I then argue that the state tries to provide a proactive solution for the dangers that may be linked with the child's environment.

Part of the environment is the *inyunyu*. On this *inyunyu*, (see figures 23 and 24) a cement and wood precarious makeshift crossing bridge was made by residents for movement of people, including children, between the east and the west sides of the informal residential area of *Ezimbacwini* that are divided by this *inyunyu*. As can be seen on the map (Figure 18), there are five of these *inyunyu* that cut through the maze of shacks *Ezimbacwini*. This is the context of the children and mothers with whom I worked. Mothers, Siya and Nompumelelo also shared with me their experiences of living next to *inyunyu*. It was often presented as metaphors around health and dignity. Nompumelelo highlighted the breathing in of 'dirt' when I visited her during one of the days of my fieldwork.

When I arrive at her house, her door is open. She peeps her head out the doorway, 'hey, nguwe (it's you). Ngena (come inside),' she welcomes me.

'Hello Nompumelelo, how are you?' I ask as I walk inside her house. Gloria is already here. Sun rays unshyly beat through the holes on the sheets, making bright circles on the brown carpet.

'I brought you the Echo [the local newspaper],' I say as I pull it out of my bag.

'Uh, just give me the Classifieds section, that is all I am interested in. Thank you,' she says taking it from my hand. ... 'I am sorry for the smell. We are breathing dirt here.'

[Field notes]

Siya also raised concerns about contracting diseases from *inyunyu* a number of times.

It is National Women's Day in South Africa, therefore a public holiday. Gloria and I find Siya at home. ... We live in the dirt and we will be attacked by diseases.

[Field notes]

The state understands the health risks of living too close to *inyunyu*, and, there have been numerous attempts to move people to suitable areas where a promise to build proper houses for them is made. In the meantime, the state, through the use of the

booklet has attempted to counter some of the risks that may be associated with living conditions, such as living next to *inyuny*. As seen in *Figures 9, 10 and 11*, which shows pages 10, 11 and 12 of the booklet respectively, the state focuses on ‘Health Promotion Messages’, part of which manage diarrhoea. Human waste, for instance may give the children diseases such as cholera, typhoid, hepatitis, and polio. These are concrete health dangers that might affect children. The state plays a double role; on the one hand it warns about health dangers, on the other, it regulates urban space such that some people have no choice but to live in unsanitary environments.

Immunisations make a child live

The state suggests to the mothers it will help the mothers make the child together with the state if the fathers are not there. Hoffman (2010) argues that mothers and caregivers raise children in sometimes hazardous surroundings, and that understanding this precarious nature of some environments is key in grappling with social life. In page 12 of the RtHB, as one of the ‘health promotion messages’, ‘play’ is encouraged. Therefore, social realities may be seen to be contributing factors to how people manage their wellbeing. Scheper-Hughes and Lock observe that health meaning is constituted in the ‘natural and the social worlds’ (1987:7). The state has the power to document. Mothers are expected to be able to read the indicators for unwell children. They are supposed to keep up with the booklet by understanding and following it.

One of the things the booklet is used for is to keep track of immunisations. The immunisations as the child receives them in stages are recorded on page five of the booklet, which is *Figure 4* in Chapter One. Therefore, the booklet is a valid data source for immunisations. Under immunisations, mothers did not think they needed to understand exactly what the immunisation abbreviations stood for. They placed their trust on the state via the nurses and the doctors.

The state offers the following immunisation injections as listed in the booklet. The ‘BCG’, which is the Bacille Calmette Guerin is to prevent Tuberculosis (TB) and meningitis (WHO, 2018). The ‘OPV’ is the Oral Polio Vaccine which is given to the child at birth, and again in six months. The ‘RV’ is the Rotavirus Vaccine that protects the child from bacteria that causes inflammation of the stomach and causes diarrhoea, nausea and fever. (WHO, 2013) This vaccine is given at 6 weeks and at 14 weeks. The DTaP-IPV-Hib, which is the Diphtheria, Tetanus, Acellular Pertussis, Inactivated Polio Vaccine & Haemophilus influenzae type b combined is given to the child at 6,

10, and 14 weeks. The last dose is given at 18 months (Jacob and Coetzee, 2015). This is a combined vaccination that protects children from diphtheria, tetanus, pertussis, polio and serious diseases like meningitis. The ‘Hep B’ is a vaccine that protects children from hepatitis that attacks the child’s liver (Western Cape Government, 2018). The ‘PCV’ is the Pneumococcal conjugate vaccine (Dlamini and Maja, 2016). This is protection from bacteria that may lead to lungs and brain infections. The babies receive it at 6 and 14 weeks, and the last dosage is given at 9 months. The Measles vaccine is given at 9 and 18 months. The ‘Td’ is the diphtheria toxoid. This vaccination is given to the child at 6 years. Over and above the immunisations, the state also supplements the children’s nutrition.

The State in support of child nutrition

Food that is rich in Vitamin A, such as spinach, yellow sweet potatoes, and full cream milk is not readily available for all mothers in South Africa. Therefore, a six-monthly supplementation with Vitamin A of children is compulsory, from month six old to 60 months (five years). The ‘Analysis of the Children’s Sector in South Africa’ prepared and compiled by Patricia Martins observed that, ‘There is a national prevalence of 43,6 percent Vitamin A deficiency.’ (Save the Children South Africa, 2015:32), which may be an indicator of the nutritional status of the mothers who breastfeed, or other commitments such as school and work (Cole 2002; Kibel & Wagsstaff 2003).

Therefore, part of what the book does is also delineate maternal responsibilities and enable a reading of mothers as having failed to breastfeed. It is presented by the state as a social barometer, or as a measure of maternal function as well as infant wellbeing.

Lack of breastfeeding, and especially lack of exclusive breastfeeding during the first half-year of life, are important risk factors for infant and childhood morbidity and mortality that are only compounded by inappropriate complementary feeding. The life-long impact includes poor school performance, reduced productivity, and impaired intellectual and social development. (World Health Organisation, 2003:V).

The state may further also supplement the infant or child with Vitamin D to strengthen and promote good bone growth to prevent development challenges such as ‘wasting’. ‘Wasting’ refers to ‘Weight for age’ as a result of malnutrition (Department of health, 2008). The plotting graph for this is found on the 17th and the 18th page of the booklet (see Appendices 6 and 7). Children born under 2500g are considered by the state to be under the normal weight at birth (Department of Health Republic of South Africa,

2013). Another measurement that assists with determining ‘wasting’ is the ‘Mid-Upper Arm Circumference’ (MUAC) found on page 19 of the booklet. The MUAC is measured in centimetres. A measuring of below 11.5cm ‘indicates acute malnutrition’ (RtHB, 2011:19).

The reduction of poverty after the demise of apartheid is attributed largely to South Africa’s expansive social protection program. A key driver of this growth has been the Child Support Grant established in 1998. Although the grant was not intended only for women caregivers of children, it is accessed mainly by women. (Patel, 2012:106)

The child support grant is open to all mothers or caregivers who meet the requirements of the Department of Social Services ‘means test’ in South Africa. This ‘means test’ means a single parent has to earn less than R3800.00 per month, and a married couple, less than R7600.00 per month to qualify. This is one of the state activities to prevent malnutrition, particularly for mothers who are not exclusively feeding their children.

Conclusion, child development risks minimised

In an attempt to make a well-child, the state guards against what can be referred to as ‘missed opportunities’ in treating potentially at-risk children timeously. Through the RtHB, the state has pre-empted the social environment in order to prevent diseases that may attack children. There is a chance children can contract diseases in Masiphumelele due to the living conditions and high unemployment, as access to nutritious foods that give children the balance they need to support their bodies is limited. The state further responds to the latter by making child social grants available. By virtue of the existence of the monitoring of children’s lives, and healthcare facilities, the state understands that the children in Masiphumelele do not exist in a perfect environment. The consequences of not caring for children who live in the circumstances such as next to *inyunyu* may be severe, and lead not only to a high prevalence of morbidities, but an increase in the mortality rate too.

The state monitors this for the reason that infants and children are at a higher risk of soil-transmitted infections and bilharzia (UNICEF, 2011). On Page 9, Figure 8, the ‘Deworming treatment’ at six-monthly intervals, starting from 12 months to 60 months is tracked. Sanitation and the provision of clean water is crucial to accompany the ‘Deworming treatment’ offered by the state. *Inyunyu*, dirty, slimy small creek, unavailability of portable inside the home water, narrow confines of *Ezimbacwini* in Masiphumelele where there are no play areas for children, resulting in them playing in

the dirty sand and *inyunyu* (see *Figure 19*), all point to the need for a stricter deworming program.

The healthcare worker, representing the state is crucial throughout the mother's pregnancy, and, particularly at delivery to observe and record 'neonatal information'. The information required here is filled in by health care officials on each scheduled visit. This is in line with IMCI, which is the Integrated Management of Childhood Illness which are the, overseen and managed by the WHO (WHO, 2018). One of the things the booklet achieves is the prevention of repetition of the same treatment which could be dangerous for children (Harrison et al, 2005). The booklet is also required at crèches to verify that the child has had all the needed immunisations or what they still need to get when health officials visit the crèche. This object moving through these spaces therefore indicates a moral duty by the state, and that for the mothers it is important to keep the relationship with the state through the RtHB for their children's wellbeing.

CHAPTER SEVEN

‘A white doctor won’t know that.’ The RtHB versus indigenous healing

Introduction, ‘tinkering’ to make a child holistically well

Helman argues that human beings from a variety of cultural backgrounds throw light upon triggers of ailing health (Helman, 2001). Helman further thinks about the kind of healing and medications people choose to use. A kind of ‘tinkering’ they actively do when they come across what they deem as ill health (Mol, 2010). In this chapter I argue that the human body can be seen as an artefact made in what people deem fit in a specific circumstance to reduce pain and avert a disease. In making the child live, the RtHB is, on the one hand, complemented by the indigenous knowledge that exists in Masiphumelele, and on the other, conflicted by it. The two knowledge systems are consulted at different times, for different ailments. In South Africa, there is a prevailing discourse that seeks to understand the relationship between biomedicine and traditional indigenous healing. There are also laws which have been developed to regulate the indigenous traditional healing industry. Street (2016) observed that,

...as a consequence of the legal acknowledgement of THPs (Traditional Health Practitioners), traditional medicine products must now also be brought under regulatory measures. (326).

The RtHB does not make an acknowledgement of traditional healers or healing ways. To illustrate this, I start with the case of Siya’s child who needed an emergency reaction from Siya, her mother and her brother.

Child sick at midnight, mothers make the call on when to use the RtHB

I made the following notes from what Siya narrated to me about what had occurred the previous night.

After midnight Siya’s son [4 years old] woke up and started crying. His cry grew into a loud urgency. He covered his eyes with both his hands. Siya and her mother ripped her son’s clothes off his body. They painstakingly searched his body for anything that may have bitten him. They found nothing, and Siya’s son would not talk. Siya ran to wake up her brother. In his car they took Siya’s son to one of the local traditional healers.

After waking up the healer gave them amafutha enja yolwandle - the fat of the sea-dog (seal). They had this oil smeared on the child’s nose, ears, belly button and bum. After this he relaxed and could go back to sleep.

[Field notes]

In-between finding out about Siya's son, I had an argument in my head about being present when they get to the traditional healer again. Why should I treat the traditional healer institution different to a state health facility?

On this day, I offer to accompany them to the traditional healer. Siya's mother suggests rather not, and that I come the following day. I agree to this.

On returning the following day Siya's mother explains to me that Siya's child's imbeleko was urgent to help towards a normal life Siya's son could enjoy. Siya's mother also confirmed that the imbeleko will be done at their home back in the Eastern Cape. She stressed that she does not want the father of Siya's son to be involved.

[Field notes]

Siya's mother confirmed that it was not because Siya's son had not had *imbeleko* done that he was sick that particular night, but that it may have contributed as *imbeleko* gets the ancestors to protect the child from evil. She explained that they will first have to do *imbeleko* for Siya, as Siya had not head hers done, and then for the child. Siya's mother explained *imbeleko* as:

The introducing of the child to the ancestors and asking them to protect the child from evil spirits. This is done using a slaughtered goat.

[Field notes]

The word *imbeleko* is derived from the word *beleka*. *Ukubeleka* in isiXhosa is to carry a child on one's back, with, before cloth materials came to South Africa, the skin of a goat, and, nowadays a towel, a blanket or any material item. The thing used to tie the child to the person carrying him or her is called *imbeleko*. When the goat is slaughtered for the baby, the elders speak, saying that they are introducing the child to the ancestors, and, asking the ancestors to carry and protect the child from evil spirits.

The back cover of the RtHB, as seen in *Figure 16* in Chapter One offers danger signs. The state here encourages the mother or the caregiver to,

Take your child to the nearest clinic if you see any of the following. Child is coughing and breathing fast (more than 50 breaths per minute). Child under 2 months old has a fever and is not feeding. Child is vomiting everything. Child has diarrhoea, sunken eyes, and a sunken fontanelle. Child is shaking (convulsions). Child has signs of malnutrition (swollen ankles and feet). Child is not moving or does not wake up. You are unable to breastfeed. (RtHB Back Cover, 2011)

Siya and her mother saw the health of the son as needing urgent attention. However, the booklet did not accommodate the type of wellbeing they needed at that time. The booklet being concerned with the biological health of Siya's child, though it is in Siya's house, it did not feature as a tool in response to the health of Siya's son in this instance. Though both in the current and piloted booklet the focus on making a 'well-child' is clearly stated, it is not called up on in the need for a 'well-child' on this night. Siya's child's booklet remained in her clothing suitcase. The mothers therefore, based on their judgement, decide when to use the state through the RtHB, and when to use indigenous methods, a decision-making process that at times conflicts the state with indigenous healing.

***Imbeleko* has significance**

Ntosh had her first child's *imbeleko* done at her home in the Eastern Cape. Talking about *imbeleko* to me Ntosh also said,

It is not easy to do it anymore. It is difficult because goats are expensive now. Many families, like mine don't have goats in the kraal where you could just take as in the past. We don't have the money.

[Field notes]

Further, while talking to Nompumelelo about *imbeleko*, she told me that it has not been done for her two children.

It is important, and nothing can replace imbeleko. Not even church. The health of a Xhosa person is linked to imbeleko. There is no escaping it, even if you are an old man or old woman.

[Field notes]

Olona had *imbeleko* done in her home for her child. She also had hers when she was in primary school, in Grade 7. Sive has not had the *imbeleko* done for her child. Xoliswa and Lihle also have not had *imbeleko* done for their children. Xabisa will have *imbeleko* performed at her home '...as my baby father is a foreign national.' she said.

Xabisa's mother acknowledges that *imbeleko* may not be done as it was in the past, as in the past the new Xhosa mother remained in the hut with women for ten days after giving birth to the child. During these days the women would perform various ceremonies. She then agrees with the slaughtering of the goat. These observations suggest that health is understood more broadly than implied in the state's vision. People are securing their children's wellbeing rather than just their biological health, thereby warding off dangers of particular kinds and making specific sets of relations

possible. Siya's mother confirmed this in the structured interview towards the end of my fieldwork,

Sonwabiso: *Mama, can you explain to me when do you use traditional healers and when do you use the RtHB and the hospital?*

Siya's mother: *No. It is not that I change from the one to the other. I see them as being the same. All aiming to health. We are black [African] people. There are things the doctors won't understand about us.*

Sonwabiso: *What are those things Mama?*

Siya's mother: *Remember we have a relationship with our ancestors? Traditional healers help us connect with them. Sometimes they [ancestors] come to us in our dreams. A white doctor won't know that. But we also need the doctors. We couldn't take the child to a doctor at the False Bay Hospital for something that we clearly see needs a traditional healer [referring to the incident of her grandchild sick at night]. But if the child had pimples [a rash], or, was bitten by something and we could see that, we would then take the child to the hospital. So, I encourage both, traditional healers and hospitals.*

[Interview, 2017]

Therefore, I argue the state's RtHB to be a symbolic form of *imbeleko* in that similarly to *imbeleko*, it aims at future wellbeing. There are aspects of life a child in future cannot perform without the mother or caregiver adhering to the instructions in the booklet.

Similarly, my grandfather insisted that I could not go to the bush to be circumcised and become a man without having *imbeleko* done. Therefore, I had my *imbeleko* done during the month I was 'due' to go to the bush (initiation school). Siya's mother also narrated a story to me of her cousin whose mother had stopped believing in Xhosa traditional ways and had fully focused on Christianity. After being in a marriage for seven years without conceiving, her husband and the family of her husband were ready to kick her out. One diviner told her that her womb is facing the wrong way. After months and months of trying to convince her, against her mother's and late father's wish, she ended up agreeing to go to a traditional healer. The first healer confirmed what Siya's mother and other family members had been saying, that her cousin needed to have *imbeleko* done. A second healer suggested that she needed to take some *muti* to cleanse her womb. They went with the first healer's finding and advice. Eleven months after her *imbeleko* was done she gave birth to her first-born son. A child that saved her marriage. Likewise, the booklet also seeks to save a child's or a person's

attachment to the state. This relationship can also be seen as economic as the future adult in a child needs to work and be worked by the state.

Amafutha enja yolwandle (Raw Seal Oil), chases away bad spirits

I also learnt further about the use of *Amafutha enja yolwandle*. In the following instance I was sitting with Sive, her mother and Gloria at Sive's house. I decided to ask direct questions to Sive about *amafutha enja yolwandle*. Sive showed me that the use of *amafutha enja yolwandle* was carried through oral knowledge.

Sonwabiso: *So, for what things, or illnesses would you apply amafutha enja yolwandle to your child?*

Sive: *I can say for almost anything. It is for the general safety of the child from bad spirits. You might just find your child dying from something you don't see. Amafutha enja yolwandle can protect your child from that kind of stuff. And we don't have money to go to traditional healers all the time the child is sick. So, having amafutha enja yolwandle in the house always helps. When my boys were younger, my mother brought amafutha enja yolwandle for me. I used to apply them on their head, ears, in front of the nose and bum.*

Sonwabiso: *Okay. Did you know them [amafutha enja yolwandle] before your mother brought them for you?*

Sive: *No.*

Sive's mother: *This has been going on for years and years. I learnt it from my mother too and it was passed on by the elders to her.*

[Field notes]

I further asked the other mothers about the protection of a child from bad spirits. Three of the mothers also encouraged the use of *amafutha enja yolwandle* for the child's wellness. Xoliswa said,

I would advise every new mother to have amafutha enja yolwandle in the house. It is cheap [inexpensive]. With R20 you can get a bottle.

[Field notes]

Amafutha enja yolwandle, can be bought from traditional healers, herbalists and I have heard a few times while travelling on the train the train mobile vendors advertising to be selling them. Ntosh also encouraged the use of the oil,

Amafutha enja yolwandle really give me confidence on my children's safety. I buy a bottle even before I give birth.

[Field notes]

It was Xabisa who was not entirely convinced about *amafutha enja yolwandle*. However, she allowed it to be used on her daughter.

It is my older sister who is really into those things [believes in traditional healing]. I let her do it because it does not harm my baby. If this stuff

works or not, I am really not sure. I know there is ubugwirha [witchcraft]. But at the same time, I don't really have proof of that.

[Field notes]

Nompumelelo, Lihle and Olona also believed that having *amafutha enja yolwandle*, as well as other traditional *muti* is important to chase away bad spirits from around the baby.

Conclusion, a child's wellbeing is not only biomedical

The mothers believed that the RtHB should be used in conjunction with traditional medicine, stressing that the one needs the other. Next to relating health and wellbeing to ancestors, the mothers also followed other methods that were not accommodated in biomedicine.

CHAPTER EIGHT

A Conclusion, the RtHB, a state call answered by the mothers

The objective of this research has been looking at the RTHB in the context of the resource-poor community of Masiphumelele. I have approached the booklet as an artefact of contemporary governance in the management of child wellbeing, and, in relation to actually lived lives of the mothers and children in the township. It is evident that the children and mothers need the state's 'pastoral' care the most here. The RtHB as a biomedical tool maintains continuity into the township and still manages effectiveness in a place with a myriad of socio-cultural challenges and flexibilities in traditional and indigenous knowledges. Furthermore, through the RtHB an extraordinary set of relations between the local and global policies of healthcare was observed. The state has international obligations to reduce infant and maternal morbidity and mortality. The state is also signatory to a range of international protocols including the SDGs. It needs to have the ability to report on children well-being. To do the latter, the state needs to have records. The booklet is therefore a way to assist the state to get to its ideals.

In this dissertation I have demonstrated how the modern state attempts to solve two problems. The first one is how the state tries to manage the individual. Through the RtHB, the state is responsive to the individual child, including the family's structure and their possible health issues. And it inserts children and their carers into a particular rhythm governed by clinic visits, themselves governed by the timing of injections and measurements (Ferreira, 2016). Secondly, the booklet further manages the relation between the now and the future by ensuring wellbeing on children for a longer healthy life in adulthood.

There is also a political will in South Africa on the implementation of the Road to Health Booklet. An example of the latter is found in an undertaking made at the Mowbray Maternity Clinic in Cape Town on the 31st of May 2011, by the then provincial minister of health, Theuns Botha when he stressed that the onus of the success of the RtHB as administered by the DoH lies with the health care worker and the mother.

It [the RtHB] will enable us to detect and treat disease at a very early stage, which will be less costly than the treatment of serious diseases at a later stage in a child's life. Now it is the parent or caregiver's responsibility to ensure that every baby's booklet is filled out... (Botha, 2011).

The RtHB is therefore a baton handed to the mother by the state in the relay race to achieve all listed objectives towards child wellbeing within set periods of time. The mother is tasked with the responsibility of making all of the bodies live and work. It is therefore the state's invitation to the mothers and caregivers to reflect continuously on their children's health. Through the use of the RtHB, part of my conclusion is that it can be interpreted as a tool for an inclusive project of the health department.

The booklet holds a complex relation between the object, the booklet itself, multiple sets of relationships, the mother and the child's father, the mother and state, the child and state. The call of the state to periodically see the child was influenced by these complex relationships in their homes and environments. It is therefore the state's invitation to the mothers and caregivers to reflect continuously on their children's health. The child gets dual care, provided by the state and by mother's own networks and innovations and indigenous knowledge.

All the mothers handled the RtHB with caution and were responding to its call for a collaborative effort towards the wellbeing of their children. Using the 'pastoral power' and 'governmentality' lens, in this dissertation I have shown how mothers themselves and children are entities to be influenced by such state power approaches. Foucault argues that pastoral power is driven by people themselves (1982). Mothers did not fail to keep the RtHB, and, to take their children to health facilities. With the exception of Xoliswa, who had lost her RtHB in a shack fire, mothers knew when their next 'well-child' visits dates were. Mothers have made themselves subjects by allowing the state's wellbeing care of their children and themselves. The state's shepherding of the mothers is influenced by culture and patriarchy, where mothers embody and agency that is within culture and state. The state achieves order through the RtHB, and, mothers and caregivers fit into that order. A further finding has been that the RtHB is not yet a pedagogical tool in Masiphumelele.

Knowledges produced past each other for the same overall objective

Though the mothers all spoke about the booklet as being support to them, there are instances where the state complements other knowledges on child wellbeing the mothers have. For instance, the booklet does not have a suggestion on how to *ukufahla*

inkabi (treating the umbilical stump). Though not covered in the booklet, the state representatives encourage what mothers are doing in this regard. The latter is best described by Lihle, who told me about the process of *ukufahla inkabi* (healing and preparing the umbilical stump.)

My mother helped me with the umbilical cord. Every time after we bathed my baby, she would wet a piece of cotton wool with surgical spirits and gently apply it around the stump. In four days, the cord fell off and my baby's bellybutton was forming nice.

[Field notes]

Therefore, mothers continue to assert their ways in instances where knowledge, between the state and the mothers, was produced past each other. I found another example with Lihle. Visiting Lihle's mother on one of the days during my fieldwork,

To my surprise, Lihle is at home today. I was not expecting to see her as she told me last night that she will be gone to look for work. I thought I would be welcomed by her mother who looks after the child when Lihle is not at home. 'Hey Lihle, you are here!'

'Yes, I did not go look for work today.'

As I am about to ask why I realise that she does not look well. She is holding onto the back of her neck. 'Is everything okay?' I ask.

'It's a girl, or woman thing. You won't understand.'

She's on her period. I think to myself. 'Don't worry. You really don't have to tell me. I understand.'

'No, you don't,' she says with a slight forced giggle.

And then, 'Ngamabele am, abuhlungu. (It's my breasts, they are painful.)'
She tells me without warning.

'Do you know what is wrong with them?'

'Ja, too much milk. My son does not want to breastfeed anymore. We made the mistake of giving him formula milk when I went to look for a job two weeks ago. Now he does not want breast milk but only wants the sweet formula milk.' *Umama wam uthe kufuneka ndiyokuwtshisa amabele (my mother said I should go and burn my breasts.),' she shares with me.*

[Field notes]

Lihle explained *ukutshisa amabele* as a process to force the breasts to stop producing milk. The RtHB did not say anything about expressing milk and trying that to get the child to drink it. I am aware that the new piloted RtHB does encourage expressing milk. However, would Lihle's son have wanted it? Lihle confirmed it is the taste that her son did not like any more about breastmilk. This makes me think about how the RtHB does not say anything about the mother's body. If the RtHB insists that mothers should breastfeed for a period of six months, then the breast is still an extension of the child.

A few days later after Lihle told me about her painful breasts I accompany Lihle to the nearby local church. She needs to 'burn the breasts'. Gloria said to me on the phone that she would be joining us a

little later. I wanted to be at Lihle's house early. I learn that Lihle's mother had made the appointment already for Lihle.

The church is a grey building. A woman dressed in white clothing at the door asks if I am the father of the child. 'No Mama, I am not.' I quickly reply.

Lihle gently looks at me. 'Do you think you can wait?' she asks.

'Oh yes, I am happy to wait for you out here. I'll wait outside here,' I reply.

It is barely ten minutes and Lihle comes back out. 'Come let's go,' she invites me.

'Is that it? Are you done here?'

'Yes, they wanted to send me to go buy some medicine from the pharmacy and come back here with it.'

'Oh okay...'

'Me, I told them I want something natural in my body. They then said another option would be to put cabbage leaves on my breasts.'

'For how long?'

Lihle shrugs her shoulders.

[Field notes]

There are related risks with not breastfeeding and managing the milk while it is still in the mother's body to prevent possible future cancers. These cancers may negatively affect the mother's ability to breastfeed in the future. Victora et al., (2016) observed that though there are numerous studies that suggest that breastfeeding reduces the risk of breast cancer, evidence has rather been diverse. 'Breastfeeding benefits mothers. It can prevent breast cancer, improve birth spacing, and might reduce a woman's risk of diabetes and ovarian cancer.' (2016:476). There are further studies that have made findings related to not breastfeeding at all after giving birth.

No interactive RtHB teaching of mothers by healthcare workers

When people pick up the booklet what they are actually holding in their hands is an amazing artefact of a particular set of knowledges and debates. In a way, it is a mystical document; it operates like a mystical object in a ritual in that its jargon can only be deciphered by some and that deciphering produces specific sets of results around greater surveillance, intervention and supplementation. Something as every day as the book that the mother receive at the clinic is an artefact, and as such, it tells about relations. The booklet therefore is a very delicate and careful tool for understanding and monitoring child and mother wellbeing.

Given that there is no training or an induction to the management of the booklet for the mothers, it still achieves its goals of getting the mothers back to the health facility at the mentioned intervals to achieve child wellness. The booklet is also intended to be

a reference where the mothers can check what the state is giving their children to encourage a natural growth course, or to transform their children's bodies. However, the state goal of also offering the RtHB as a pedagogy of care tool is not being fully realised as the mothers explained that it was not discussed by the nurses when they visited healthcare facilities. Mothers in my research emphasised to me that after looking at the booklet for 'umhla olandelayo wekliniki' (the next clinic date), they would never look at it again. Olona offered one example of a time with a healthcare professional when I wanted to know what happens when she is at the clinic.

Olona: I put my child's clinic card at the window.

Sonwabiso: Which card is this?

Olona: This one [points to her daughter's RtHB on the table]. My child only has one card.

Sonwabiso: Okay. Where is this window? And what do they do with your child's clinic card?

Olona: The window as you enter the clinic. They take the card and tell you to sit down and wait.

Sonwabiso: Okay.

Olona: How long you wait depends on how busy the day is. After a while they call your child's name to the nurse's room. There the nurses have a folder with the child's card in it. They take the child's weight and write stuff.

Sonwabiso: What are they saying to you in this time?

Olona: About what?

Sonwabiso: I am trying to know if there is a conversation between you and the nurses this time, and what it would be about if you can share.

Olona: Oh. They would ask what I am feeding the child. How I am coping with raising the child and things like that.

Sonwabiso: You said they write stuff. Can you tell me more?

Olona: I can't tell you what they write because they don't tell me. The only thing they would show me is the next date to come to the clinic on the card.

[Interview, 2017]

This is a missed opportunity to equip the mother with further knowledge to manage children wellbeing.

Conclusion, child, mother and state relationship normalised

I have argued that the RtHB is a form of 'governmentality', a mode of 'pastoral power', that tries to curb uncertainty and instability in the lives of the population of South Africa's children. With monitoring and tracking using the RtHB, the state tries to ensure a set of measurements that will enable appropriate medical and nutritional interventions early, and to secure well-being through close monitoring of the child. It also tries to instil a particular mode of attention to the child that will enable mothers

and caregivers to monitor infant well-being, that is, to become responsible in particular ways for the life of the other. The RtHB gives the mothers and the children access to the state and vice versa, and, normalises these interactions. The South African Health department seeks to make the most of the use of the RtHB. Thus, the RtHB is a key component in the state's endeavour to make children live, as well as mothers responsible.

Therefore, the RtHB requires full participation of the mothers and caregivers who meet their assigned obligations by the state, for the state to achieve the making live of children. The RtHB is a contract where the mothers accept their part of responsibilities. This, therefore, means that the RtHB is not 'epistemic violence' on society. The RtHB is a very delicate and careful tool for understanding and monitoring child and mother wellbeing. Achieving wellbeing for children involves a range of relationships that the RtHB helps manage.

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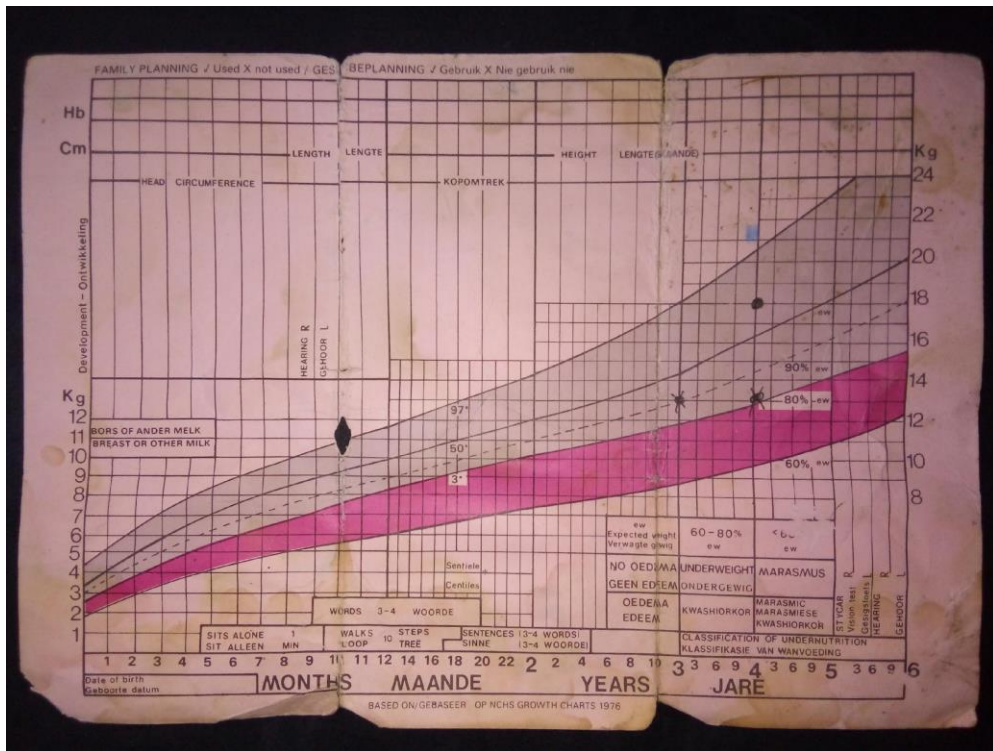
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Pre-School Health Card belonging to the author

PERINATAL DATA/PERINATALE DATA		PRE-SCHOOL HEALTH CARD VOORSKOLLE GEZONDHEIDSKAART		CLINIC/HOSPITAL ATTENDANCE KLINIEK/HOSPITAAL BESOEK	
Mother's name Moeder's naam		This card must be shown every time the child attends Clinic/Hos- pital/Gesondheids Centrum Moeder's name must also be shown on Clinic/Hospital/Gesond- heids Centrum Dokter's name		Health/Mentique Date Datum	
Hospital number Hospitaal nummer		Local Authority Plaatselijke Overheid		Grade Graad	
Date of birth Geboortedatum		Surname Van		TB Contact TB Kontak	
Sex Geslacht		Child's Name Kind se naam		TB Notified TB Aangemeld	
Birth weight Geboortegewig		Kind se woonplaas		Date Datum	
Gestational age Gestuuwde ouderdom		Male/Female Mans/Vroulik		Child's Father's Number/Kind se Vader se nommer	
Length Lengte		Address Adres		Hospital/Clinic/Health Centre Hospitaal/Kliniek/Gesondheidsentrum	
Head circumference Kopomtrek		Immunisations/ Innemmings		Number Nommer	
Siblings Broers en suster		Date/Datum		Place/Plaas	
Mother Moeder		Anti-TB/BCG		Other medical information and notes Ander mediese informasie en notas	
Baby Baba		41.07.84			
Baby Baba		24.10.84			
Baby Baba		19.12.84			
Baby Baba		20.01.85			
Baby Baba		24.10.84			
Baby Baba		19.12.84			
Baby Baba		20.01.85			
Baby Baba		24.10.84			
Baby Baba		19.12.84			
Baby Baba		20.01.85			
Baby Baba		24.10.84			
Baby Baba		19.12.84			
Baby Baba		20.01.85			
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Baby Baba		24.10.84			
Baby Baba		19.12.84			
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Baby Baba		24.10.84			
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Baby Baba		24.10.84			
Baby Baba		19.12.84			
Baby Baba		20.01.85			
Baby Baba		24.10.84			
Baby Baba		19.12.84			
Baby Baba		20.01.85			



While the state's intention appears clear, this card demonstrates a lack of interest in completing it by healthcare workers. What about my mother though, could she not have asked for it to be completed in full, or, complete it herself?

A copy of the 'Ciskei General Health Card' belonging to the author

PAST MEDICAL HISTORY <small>(all major illnesses, operations, allergy, obstetrical history and abnormal PAP smears)</small>		DATE	NOTES	RETURN DATE & SIGNATURE
		05-10-28	<p><i>chest pains</i></p> <p><i>Productive cough - Epinephrine</i></p> <p><i>White</i></p> <p><i>Bundles x 1 day</i></p> <p><i>R. 1) Penicillin i pr</i></p> <p><i>2) Quinine 10ml qd</i></p> <p><i>3) Mucilago 3qds 10ml tid</i></p> <p><i>4) Quinine 3qds 10ml tid</i></p> <p><i>5) Bar. 10 3rd in sat 13gms</i></p> <p><i>9 May 1929</i></p>	
Remarks. Family medical and any relevant social history.				

BLOOD GROUP	AGE	SEX
YEAR		
BASELINE WEIGHT		
BASELINE BLOOD PRESSURE		

Appendix 3

An extract from a story by the author published online

One day when we were young boys we went to pick prickly pears – *itolofiya*. It was a summer day in the Eastern Cape with no wind; just the smallest of breezes that might lift a page off a teacher's table. But this light wind could blow prickly pear thorns.

I was about to learn a lesson I had not been taught yet, by the boys who had done this before. Many of them were older than me. I was very hungry, the hungriest boy in the bunch. When we got to the clump of prickly pears I used a bent wire to try and reach one that looked just right. It was golden. On the first attempt I failed, but I was determined not to fail again. I walked around searching for a better angle to get the pear from. Then I reached up and poked with the bent wire. It slipped. I quickly reached again. My eyes were wide open as I brought that golden prickly pear down. That's when something fell in my eye. I ran screaming in pain and tripped over *isiduli sembovane* – an ant sand heap.

'Hey, Lungile, where are you running to?' Zuko shouted. In no time the boys were around me, helping me home. My one eye was blood red. 'What did you think, Lungile, you must always look at the direction of the wind.' Zuko said. His advice was a bit late!

I was taken to the nearest clinic where an ointment was applied to my eye. They assured my mother that it would work. We got back home and the swelling was not going down. A broken piece of the thorn was still stuck in my eye. I overheard my mother talking with other ladies from the village. I knew that I needed help. I was taken off by my mother to a lady who had a new born baby and was breast feeding. I was told to sit in front of her. She whipped out her left breast and squirted breast milk into my eye. That night when I slept the one eye was tearing and the piece of thorn washed out with the tears – I was healed.

That was the first and the strangest way of healing I have ever experienced. 'You know Zuko it's good to let older people who care for you, do their own thing.' I told my friend afterwards.

Reference:

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Appendix 4

When I spoke to 'white' boys for the first time – a story of how bodies are carried in language

It is January of 1996. I am to start my Grade 6 at the Ukhanyo Primary School here in Masiphumelele.

Myself, and Sba my friend were walking from the township to the liquor store near the Pick 'n Pay in Sun Valley (The Long Beach Mall had not been built then). We carried polypropylene bags, both filled with empty beer bottles we collected in the township. We would return them for a small refund. If it was not enough to buy our favourite swiss roll cake at Pick 'n Pay, we came straight back to the township to buy a mixture of biscuit offcuts.

Each time we would arrive at the liquor store and stand just outside the door until we got the attention of one of the staff members. We would then signal to them that we are going around the back. From behind the metal sheet window, the store manager, an ever-smiling coloured man with a white perfectly trimmed beard would count the empty bottles with us.

On this day, we stopped every fifty metres or so. The bags were too big for our backs. When we came off Kommetjie road we turned in to a straight road that would lead us to Pick 'n Pay. We stopped in front of an unfenced house with a perfect lawn. We made sure not to sit on the lawn or put our bags on it. We sat on the edge of the pavement and rested.

'Look, boys on bicycles,' Sba pointed to his left. I turned to look. About seven boys, abelungu, white, roughly our age were riding towards us. They got to us and parked their bicycles. They were very kind, curious. Sba was struggling to keep up with their questions. I did not understand much English, so I left that to Sba. But I did not quite want him to know exactly how bad my English was either.

I couldn't stop looking at the bicycles. How I wished I could ride one of them. Lovely BMX's and Mountain Bikes. Clean chains. So many gears! I could ride on these forever. They had brakes that looked like they worked perfectly. In the village only one boy had a bike. His did not have chain gears, no brakes, no tires. If you needed to stop immediately while going downhill, you stuck your strong foot hill between the back wheel and steel. Or swerved for the bushes if a goat or a sheep was crossing the track you were in. Here I was looking at heaven.

Sba nudged me with his elbow on my ribcage, 'hey, are you dreaming? They are asking whose bike you like.'

'Oh,' but I was not going to tell him in isiXhosa and let him translate. 'Sure, that fat boy's one,' I said with a smile looking at the boys.

The 'fat' boy came fast to me, biting his teeth and eyes, wide open, 'do you believe in God! Do... you... b e l i e v e... in God!'

He was the first to take his bike and ride away. Some of them turned back and threw middle fingers at us.

Sba clenched his fists, 'Sonwabiso, you fucking stupid!'

'What!'

'We were making our first white friends. And they were about to let us ride their bikes, one at a time. You fuckin' ruined it for us. Udom udom man (you are dumb, you are dumb man).'

'What did I do?'

Sba threw his hands in the air, he turned his head away and back at me, 'you called the boy fat. Stupid!'

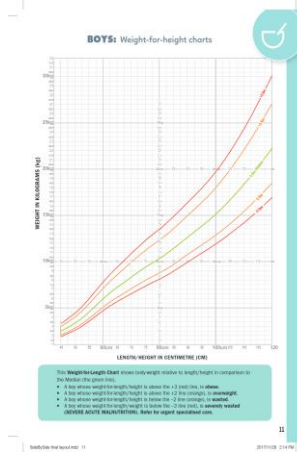
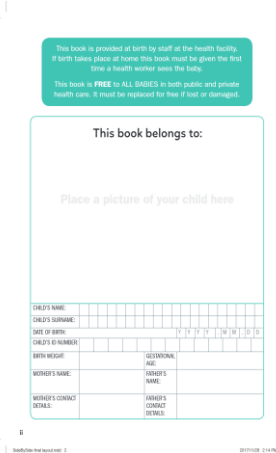
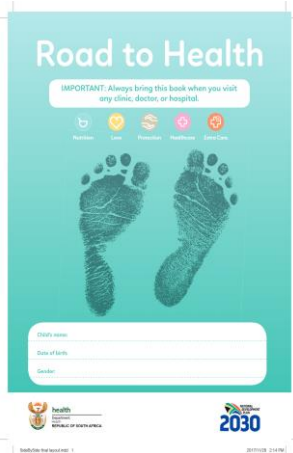
'And, what is wrong with that?'

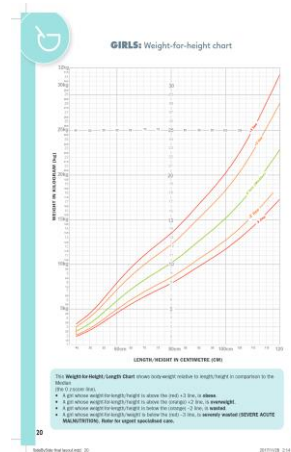
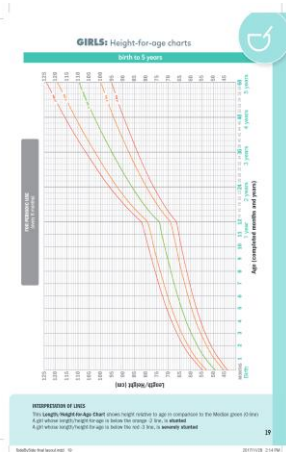
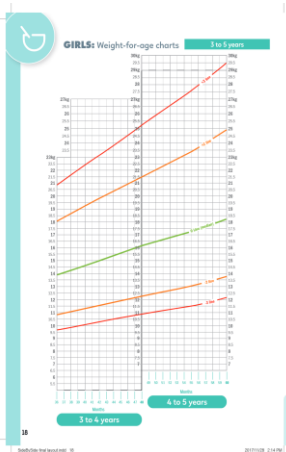
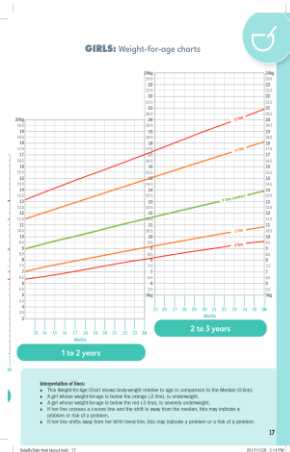
'Everything is wrong with that...'

[Memories from the township]

NOTE: In the encounter above, I learnt, the hard way how human bodies are embedded in language. I did not know better, for this context. '...bodies tell stories that people cannot or will not tell, either because they are unable, forbidden, or choose not to tell.' (Krieger, 2005:350). From the background I came from, calling someone fat was a complement. I described this kind boy using my available vocabulary. Now I am aware, that context can be everything.


Appendix 5



[illegible]

Immunisations

EPI (Expanded Programme of Immunisation) Schedule



Child's Name		Child's Date of Birth			
Age	Varicella	Polio & Tetra	Booster no.	Date given	Signature
Birth	OPV0	One			
	OPV1	One			
	Measles 1	One			
	PTC1	One			
		Right thigh			
0 months	Measles/PTC	One			
	OPV (polio-vib-HEB5)	One			
	Measles/PTC	One			
10 months		Left thigh			
	Measles/PTC	One			
	OPV (polio-vib-HEB5)	One			
14 months		Right thigh			
	Measles/PTC	One			
	OPV (polio-vib-HEB5)	One			
18 months		Left thigh			
	Measles 1	One			
	Measles 1	One			
0 months	PTC 2	One			
	Measles 2	One			
	Measles 2	One			
6 months	PTC 3	One			
	Measles 3	One			
	Measles 3	One			
18 months	PTC 4	One			
	Measles 4	One			
	Measles 4	One			
24 months	PTC 5	One			
	Measles 5	One			
	Measles 5	One			
30 months	PTC 6	One			
	Measles 6	One			
	Measles 6	One			
36 months	PTC 7	One			
	Measles 7	One			
	Measles 7	One			
42 months	PTC 8	One			
	Measles 8	One			
	Measles 8	One			
48 months	PTC 9	One			
	Measles 9	One			
	Measles 9	One			
54 months	PTC 10	One			
	Measles 10	One			
	Measles 10	One			
60 months	PTC 11	One			
	Measles 11	One			
	Measles 11	One			
66 months	PTC 12	One			
	Measles 12	One			
	Measles 12	One			
72 months	PTC 13	One			
	Measles 13	One			
	Measles 13	One			
78 months	PTC 14	One			
	Measles 14	One			
	Measles 14	One			
84 months	PTC 15	One			
	Measles 15	One			
	Measles 15	One			
90 months	PTC 16	One			
	Measles 16	One			
	Measles 16	One			
96 months	PTC 17	One			
	Measles 17	One			
	Measles 17	One			
102 months	PTC 18	One			
	Measles 18	One			
	Measles 18	One			
108 months	PTC 19	One			
	Measles 19	One			
	Measles 19	One			
114 months	PTC 20	One			
	Measles 20	One			
	Measles 20	One			
120 months	PTC 21	One			
	Measles 21	One			
	Measles 21	One			
126 months	PTC 22	One			
	Measles 22	One			
	Measles 22	One			
132 months	PTC 23	One			
	Measles 23	One			
	Measles 23	One			
138 months	PTC 24	One			
	Measles 24	One			
	Measles 24	One			
144 months	PTC 25	One			
	Measles 25	One			
	Measles 25	One			
150 months	PTC 26	One			
	Measles 26	One			
	Measles 26	One			
156 months	PTC 27	One			
	Measles 27	One			
	Measles 27	One			
162 months	PTC 28	One			
	Measles 28	One			
	Measles 28	One			
168 months	PTC 29	One			
	Measles 29	One			
	Measles 29	One			
174 months	PTC 30	One			
	Measles 30	One			
	Measles 30	One			
180 months	PTC 31	One			
	Measles 31	One			
	Measles 31	One			
186 months	PTC 32	One			
	Measles 32	One			
	Measles 32	One			
192 months	PTC 33	One			
	Measles 33	One			
	Measles 33	One			
198 months	PTC 34	One			
	Measles 34	One			
	Measles 34	One			
204 months	PTC 35	One			
	Measles 35	One			
	Measles 35	One			
210 months	PTC 36	One			
	Measles 36	One			
	Measles 36	One			
216 months	PTC 37	One			
	Measles 37	One			
	Measles 37	One			
222 months	PTC 38	One			
	Measles 38	One			
	Measles 38	One			
228 months	PTC 39	One			
	Measles 39	One			
	Measles 39	One			
234 months	PTC 40	One			
	Measles 40	One			
	Measles 40	One			
240 months	PTC 41	One			
	Measles 41	One			
	Measles 41	One			
246 months	PTC 42	One			
	Measles 42	One			
	Measles 42	One			
252 months	PTC 43	One			
	Measles 43	One			
	Measles 43	One			
258 months	PTC 44	One			
	Measles 44	One			
	Measles 44	One			
264 months	PTC 45	One			
	Measles 45	One			
	Measles 45	One			
270 months	PTC 46	One			
	Measles 46	One			
	Measles 46	One			
276 months	PTC 47	One			
	Measles 47	One			
	Measles 47	One			
282 months	PTC 48	One			
	Measles 48	One			
	Measles 48	One			
288 months	PTC 49	One			
	Measles 49	One			
	Measles 49	One			
294 months	PTC 50	One			
	Measles 50	One			
	Measles 50	One			
300 months	PTC 51	One			
	Measles 51	One			
	Measles 51	One			
306 months	PTC 52	One			
	Measles 52	One			
	Measles 52	One			
312 months	PTC 53	One			
	Measles 53	One			
	Measles 53	One			
318 months	PTC 54	One			
	Measles 54	One			
	Measles 54	One			
324 months	PTC 55	One			
	Measles 55	One			
	Measles 55	One			
330 months	PTC 56	One			
	Measles 56	One			
	Measles 56	One			
336 months	PTC 57	One			
	Measles 57	One			
	Measles 57	One			
342 months	PTC 58	One			
	Measles 58	One			
	Measles 58	One			
348 months	PTC 59	One			
	Measles 59	One			
	Measles 59	One			
354 months	PTC 60	One			
	Measles 60	One			
	Measles 60	One			
360 months	PTC 61	One			
	Measles 61	One			
	Measles 61	One			
366 months	PTC 62	One			
	Measles 62	One			
	Measles 62	One			
372 months	PTC 63	One			
	Measles 63	One			
	Measles 63	One			
378 months	PTC 64	One			
	Measles 64	One			
	Measles 64	One			
384 months	PTC 65	One			
	Measles 65	One			
	Measles 65	One			
390 months	PTC 66	One			
	Measles 66	One			
	Measles 66	One			
396 months	PTC 67	One			
	Measles 67	One			
	Measles 67	One			
402 months	PTC 68	One			
	Measles 68	One			
	Measles 68	One			
408 months	PTC 69	One			
	Measles 69	One			
	Measles 69	One			
414 months	PTC 70	One			
	Measles 70	One			
	Measles 70	One			
420 months	PTC 71	One			
	Measles 71	One			
	Measles 71	One			
426 months	PTC 72	One			
	Measles 72	One			
	Measles 72	One			
432 months	PTC 73	One			
	Measles 73	One			
	Measles 73	One			
438 months	PTC 74	One			
	Measles 74	One			
	Measles 74	One			
444 months	PTC 75	One			
	Measles 75	One			
	Measles 75	One			
450 months	PTC 76	One			
	Measles 76	One			
	Measles 76	One			
456 months	PTC 77	One			
	Measles 77	One			
	Measles 77	One			
462 months	PTC 78	One			
	Measles 78	One			
	Measles 78	One			
468 months	PTC 79	One			
	Measles 79	One			
	Measles 79	One			
474 months	PTC 80	One			
	Measles 80	One			
	Measles 80	One			
480 months	PTC 81	One			
	Measles 81	One			
	Measles 81	One			
486 months	PTC 82	One			
	Measles 82	One			
	Measles 82	One			
492 months	PTC 83	One			
	Measles 83	One			
	Measles 83	One			
498 months	PTC 84	One			
	Measles 84	One			
	Measles 84	One			
504 months	PTC 85	One			
	Measles 85	One			
	Measles 85	One			
510 months	PTC 86	One			
	Measles 86	One			
	Measles 86	One			
516 months	PTC 87				



Vitamin A and deworming doses

	Vitamin A	Dose	Signatures	Date	Signature
6 months	100,000 IU				
12 months			(Giving tag for 7 days)		
18 months	200,000 IU		(Giving tag for 7 days)		

Starting from 24 months, every child should receive Vitamin A and mebendazole every six months (up to 5 years of age).

Record after these doses are given, and the return date below!

	Vitamin A (200,000 IU)	Mebendazole (100 mg x4)	Return date	Signature	Return date
Date	Signature	Return date	Date	Signature	Return date

Protect your child's health

- Use a small, clean cloth to clean your baby's gums before the first tooth appears.
- Start to clean your baby's teeth as soon as the first tooth comes through.
- Once teeth appear, use a small, soft toothbrush with a small, rounded, tapered amount of child toothpaste to brush teeth.
- Brush teeth and along the gum line twice a day: in the morning and at night before bed.
- Discourage the giving of sugary snacks and drinks.
- Look in your child's mouth regularly to spot any signs of tooth decay and consult a dentist or other health worker if you notice anything unusual.
- Never put your baby to sleep with a feeding bottle (bottle-feeding). Breastfeeding or co-sleeping is always better than bottle-feeding.

Frequency of monitoring	Findings (report for signs of heart trouble, such as: legs or feet with a tinge)	Follow-up	Signature
Set visit on appearance of first tooth (or at 6 months examines communication)			
At age 12 months (examines communication)			
In the 2nd year			
In the 3rd year			
In the 4th year			
In the 5th year			

For Health Workers...

Complete the table at the specified visits, if you observe any oral abnormalities.

Indicate the assessment (X)

29

Danger signs!

Take your child to the nearest clinic if you see any of the following:

Child has **fever** and **breathing fast** (more than 60 breaths per minute)

Child under 2 months old has a **fever** and is **not feeding**

Child is **vomiting everything**

Child has **diarrhoea**, **red eyes**, and a **swollen belly**

Child is **in diarrhoea**

Child has signs of **malnutrition** (swollen ankles and feet)

Child is **not moving** or **does not wake up**

You are **unable to breastfeed**

1

1. Good nutrition to grow and be healthy

Your child needs the right foods to be healthy and grow well. Ask the health worker if your child is growing well and tell them if you are worried about anything.

Birth to 6 months:

- Breastfeeding is the best way to feed your baby. It is the ideal food for your baby to grow, develop and be healthy.
- Give your baby **ONLY** breast milk for the first six months of life. Do not give porridge, water or any other foods. Do not give any other home or traditional medicines or remedies. Only give your baby medicines they receive from the clinic or hospital.
- Breastfeed as often as your baby wants, both day and night.
- Breastfeed your baby at least 8 times in 24 hours. The more your baby feeds the more milk you will produce. Almost all mothers will produce enough milk for their baby not to need anything else for the first six months.
- You can express breastmilk for other people to give to your baby while you are away. They should use a clean cup, rather than a bottle. Store expressed breastmilk in a clean glass or plastic cup with a lid. Defrost in a fridge or at room temperature over 22 hours or by standing in water. Do not boil or microwave.

How long to store expressed breastmilk?

Storage method	Maximum storage time
Room temperature	Up to 4 hours
Fridge	Up to 4 days
Freezer (below -18°C)	Up to 6 months

2

Why should I give only breastmilk during the first six months of life?

Remember: Before you make the decision not to breastfeed, discuss the matter with a health worker if you are really unable to breastfeed, you will need to learn how to use formula safely.

- Breastmilk contains all the nutrients your baby needs for the first 6 months of life.
- Baby's tummy (intestine/gut) is not yet ready for any other foods, water or other liquids before 6 months.
- Babies may get diarrhoea, constipation, infections and allergies if other foods, or other liquids – including water – are given before the baby is 6 months old.
- Breastmilk contains enough water to quench your baby's thirst during the first 6 months of life, even in hot weather.
- Breastmilk contains special properties that keep your baby healthy. Breastfeeding reduces the chance of your baby getting pneumonia and diarrhoea.
- Giving other foods before six months will cause you to produce less breastmilk and your baby will not get all the nutrients they need to grow and develop well.

For Health Workers...

- Babies only need breastmilk and nothing else during the first six months of life. This is called **exclusive breastfeeding**.
- Mothers need help to start breastfeeding immediately after birth.
- Mothers need support to continue breastfeeding successfully. Help them to get their baby to attach properly.
- Mothers who are not breastfeeding must be counselled on correct replacement feeding.

3

6 months to 5 years

From 6 months:

What foods to give:

8-10 months:

- **Continue breastfeeding as usual. Do not stop. Then give other foods.** Your baby needs breast milk (breast milk, eggs, animal milk, formula milk, chicken or chicken soup, ground nutmeg, peanuts). These foods must be cooked and mashed to make them soft and easy for your baby to swallow.
- Also give your baby:
 - Starchy (such as boiled maize meal porridge, mashed sweet potatoes or mashed potatoes)
 - Mashed, cooked vegetables (such as pumpkin, tomatoes, carrots)
 - Soft fruit without pits (such as apples, bananas, pears, peaches, apricots)
- Give your baby meat and safe water to drink from a cup regularly.

11-12 months:

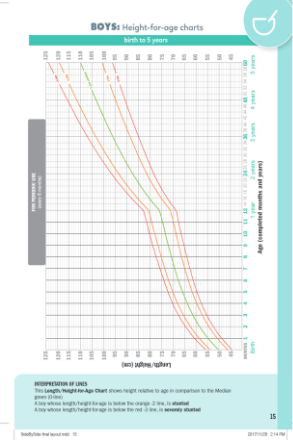
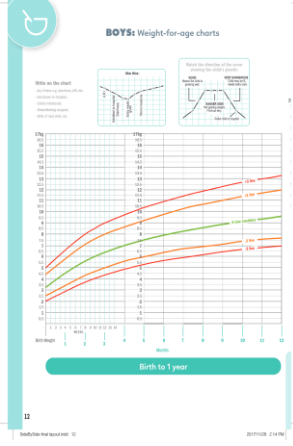
Continue breastfeeding as usual. Do not stop. Then give other foods.

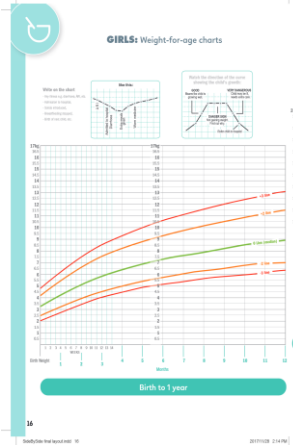
- Your baby needs to eat more solid foods. These foods are very important for your baby's growth.
- Increase the amount and variety of different foods or foods.
- Food should be cooked and mashed to make it soft and easy to swallow.
- Give your child a cup of water.
- Avoid sweet food (sweets, biscuits, cakes, etc.).
- Avoid sweet food (sweets, biscuits, cakes, etc.).
- Give your baby safe water to drink from a cup regularly.

13-15 months:

- About 4 to 5 cups, then increase to 6 to 8 cups by 22 months.
- 6 meals a day.

4





2. Love, play and talk for healthy development

Young children need a safe environment and loving caregivers who can help them explore the world around them. Exploring things through play that are safe to handle, touching, playing and reading to your child are what helps them grow and develop.



Here are some basic things you can do to help your child to develop and learn:

- **Be there for your child.** You are the most important person in your child's life. Be there for him with love and support.
- **Be with your child.** Keep your baby close to you as much as possible in the first few weeks of life. This will help to calm them and help them to sleep, grow and feed well.
- **Be responsive.** Pay attention to your child's wishes, smiles and their cries and respond to them – this will help you to understand them better and to meet their baby's needs.
- **Your baby learns from birth.** He or she hears, sees, smells and feels, especially during feeding, talking, and dressing.
- **Give your child the chance to explore and interacting with interesting things.** Give your child the chance to explore and play in a safe space and to play with clean household objects at home.
- **Tell stories and read to your child.** Look at the pictures, let him ask questions, often then tell you a story or what happened in the storybook as you go along.

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South Africa's newborn 2018

2017/18/18

3. Protection from preventable childhood diseases and injuries

Children should NOT only be taken to the clinic when they are ill. They should also take your child for the clinic twice of immunisations/ vaccines and mental health treatment sessions for the Immunisation and Mental Health Clinics at 27 and 28.

- Immunisations are given. They protect your baby from common childhood illnesses and diseases. Make sure your baby gets all two or her immunisations.
 - Go to the clinic for your follow-up visits for you and your baby within six weeks of birth and at six weeks.
- Make sure that you know where your baby needs to come for the clinic for immunisations or other visits. If you miss the date for your visit, make sure that you return as soon as possible.
- From 15 weeks onwards, your baby needs to have 10V at birth and at 10 weeks.
- All children between 6 months and five years should receive Vitamin A and deworming medicines every six months. This helps to keep them healthy.
- Remember to wash your hands after you take the child, changing nappies, before playing outside and before feeding children. Wash your hands properly, wash both sides of your hands, between your fingers and your wrists with soap and water.
- Many serious diseases can be prevented if parents and other caregivers supervise young children carefully and keep their environment safe.
- Protect yourself too. Get all your immunisations up to date. Make sure that there is always a responsible adult taking care of your child and that you know where your child is at all times.
- Protect yourself too. Decide on a contraceptive method of choice and also use male or female condoms to prevent both unwanted pregnancy and sexually transmitted infections (that protect).
- Good oral health will keep your child's teeth healthy and strong and prevent unnecessary pain and discomfort.

For Health Workers...

- Remember that you are part of the health facility is a chance to provide
 - Provide services and health promotion
 - Check the child's nutritional status and growth
 - Check the child's oral health and dental status
 - Show the caregiver proper hand washing
 - Always give the caregiver a date for her baby's next visit to the clinic.

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Healthcare for women 20

2019/10/10 14:29:40

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	Walking crawling	Visuals and action	Receptive vocabulary (e.g., "come")	Simple sentences
18 months Date: _____ Age: _____	Crawls on all fours or on knees Takes at least 2 steps after 2 years	Looks at object and brings and drops	Follows simple commands (e.g., "come")	Makes simple sentences (e.g., "I want")
2 years Date: _____ Age: _____	Climbs onto a table or onto a chair Walks on a balance beam	Sees and brings back at a distance (e.g., "bring me that")	Plays with other children (e.g., "I want that")	Uses an object (e.g., "I want that")
4 years Date: _____ Age: _____	Jumps on ball Climbs stairs Crouches Extends arms (e.g., "bring me that")	No-starts (e.g., "bring me that")	Interacts with other children (e.g., "I want that")	Uses one object on another (e.g., "I want that")

REFERRED TO:

Speech Pathology	Devic	Occupational Therapist	Psychological Therapist
Learning	Developmental Disorder	Devic	Occupational Therapist
Devic	Developmental Disorder	Psychologist	Devic
	Occupational Therapist	Speech Therapist	

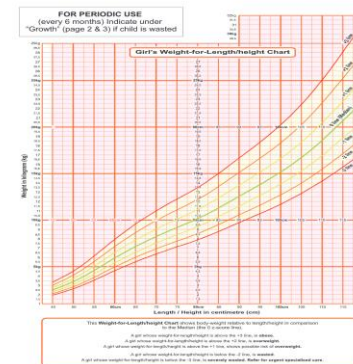
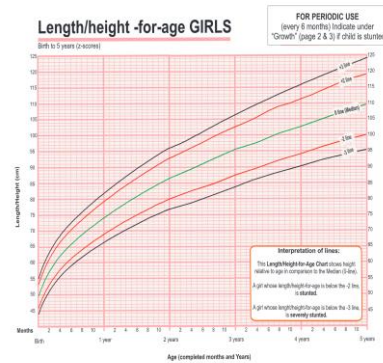
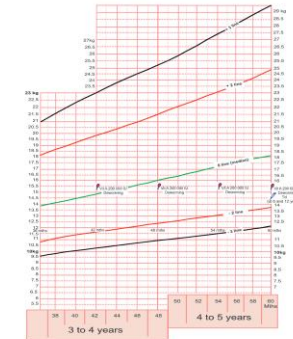
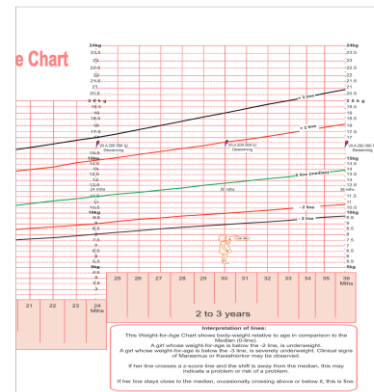
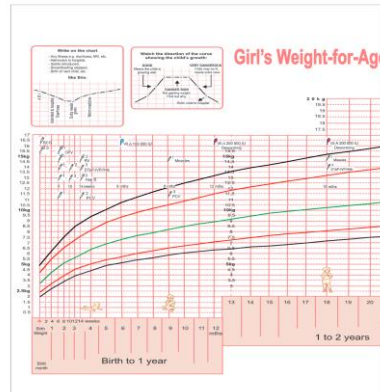
If specified how professional not available, refer to one of the following: health professionals for an individual assessment, e.g., [http://www.healthprofessionals.com.au/health-professionals](#)

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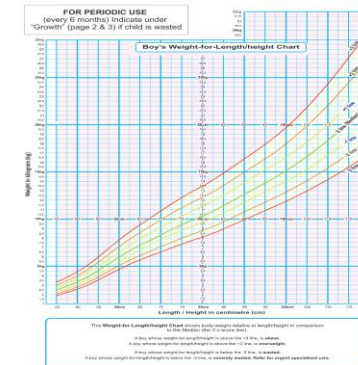
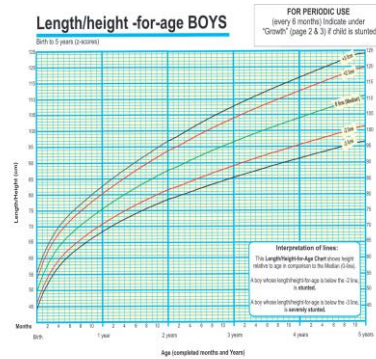
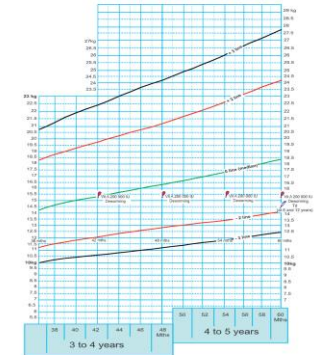
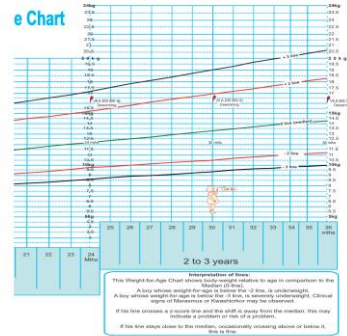
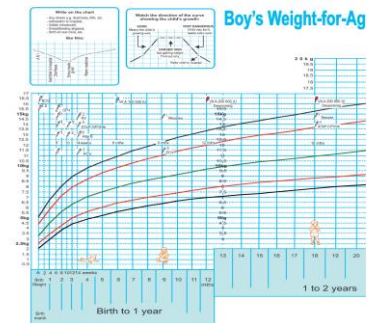
Appendix 6

Girl's Weight For Age Chart And Length/ height for age Girls



Appendix 7

Boy's Weight For Age Chart And Length/ height for age - Boys



Appendix 8

Information Sheet and Consent Form (English)

The Road to Health Booklet: Ethnography and interviews

July / August / September - 2017

Information Sheet and Consent Form (English)

I, Sonwabiso Ngcowa, a masters student in anthropology at the university of Cape Town would like to invite you to participate in a research project on the Road to Health Booklets . These booklets are issued by the Health Department of South Africa. I would like to capture the information on the Road to Health Booklet through spending time and observing how you use the booklet

This research will take six weeks to complete. I would also like to conduct formal interviews with you. For the formal interview section there are no right or wrong answers. These formal interviews will be recorded. At all times this information will be kept confidential. The information you share with us will be used in the writing up of my research findings. Furthermore, when I write my research findings I will not mention your real name.

For any questions please contact the researcher on:

Cell: 0839995729

CONSENT:

I hereby consent to participate in this research. I understand that there is no guarantee that they

will benefit me directly or my community.

Name:

Signature:

Researcher name:

.....

Signature:

Appendix 9

Information Sheet and Consent Form (IsiXhosa)

The Road to Health Booklet: i-ethnography nodliwanondlebe

Eyekhala / Eyethupha / Eyomsintsi - 2017

Iphepha Lencazelo Kunye Nemvume (IsiXhosa)

Mna, uSonwabiso Ngcowa, umfundi wemasters kwi-anthropology kwi-yinivesithi yakeKapa, ndingathanda ukukumema ukuba uthathe inxaxheba kuphando lwazi olwenziwayo ngee-Road to Health Booklets. Ezincwadana zikhutshwa lisebe lezempilo eMzansi Afrika. Ndingathanda ukufumana iincukacha nge-Road to Health Booklet ngokuthi ndibene xesha kunye nawe

ndikubukele ukuba uyisebenzisa njani na lencwadana. Ndingathanda nokuba ndenze

nodliwanondlebe ngokusesikweni kunye nawe. Oluphando luzokuthatha iiveki ezintandathu ukuze ligqibeke. Ndingathanda nokuba ndenze nodliwanondlebe ngokusesikweni kunye nawe. Koludliwano ndlebe akukho mpendulo ilungileyo okanye engalunganga. Oludliwanondlebe lizakurekhodwa. Ngamaxesha onke ezincukacha ziyakugcinwa ziyimfihlo. Iincukacha oyakuthi wabelane nathi ngazo zakusetyenziswa ekubhaleni izinto ezifunaniweyo. Ngaphezulu koko, xa sibhala okufunyanisiweyo asizukusebenzisa igama lakho.

Ukuba unayo eminye imibuzo qhagamishelana nomphandilwazi apha:

Cell: (083 999 5729)

IMVUME:

Mna ngokwenjenje ndiyavuma ukuthatha inxaxheba koluhando lwazi. Ndiyaqonda ukuba

akukho siqinisekiso sokuba ndiyakufumana inzuzo ngokunokwam okanye uluntu.

Igama:

Tyikitya:

Igama lomphandi lwazi:

.....

Tyikitya: